



District of Columbia's Managed Care Annual Performance Report

(January 2018 – December 2018)

Issued by:

Department of Health Care Finance

June 2019
Washington, DC

Presentation Outline

- ☒ **Goals and Purpose of Managed Care Review**
- ☐ Summary Of Key Findings
- ☐ The Financial Performance of the District's MCOs
- ☐ The Administrative Performance of the District's Health Plans
- ☐ MCO Medical Spending and Beneficiary Utilization Patterns
- ☐ Care Coordination and Performance Against Program P4P Benchmarks
- ☐ Conclusions

Managed Care Represents DHCF's Largest Provider Expenditure

- ❑ Department of Health Care Finance's (DHCF) managed care program is the largest single expenditure in the agency's budget consisting of the Medicaid and Alliance publicly-funded health insurance programs.
- ❑ As of December 2018, nearly 194,506 Medicaid beneficiaries and just over 15,200 Alliance enrollees were assigned to one of the four following Managed Care Organizations (MCO)¹:
 - Amerigroup DC, Inc. (Amerigroup)
 - AmeriHealth Caritas DC (AmeriHealth)
 - Trusted Health Plan (Trusted)
 - Health Services for Children With Special Needs (HSCSN)
- ❑ In 2018, all four MCOs offered comprehensive benefits during their first full year of operations under the new contracts. Three of these MCOs – Amerigroup, AmeriHealth, and Trusted – operated under full risk-based contracts while HSCSN worked under a risk sharing arrangement with the District. During the first full year of operations, the population previously enrolled in MedStar primarily shifted to Amerigroup. Subsequent to this initial population shift, a disproportionate share of the high-acuity, high-cost MedStar population ultimately transitioned to AmeriHealth from the other two full risk-based MCOs, leading to unforeseeable operating and financial challenges for AmeriHealth in 2018.
- ❑ The District spent roughly \$1.1 billion² on MCO services in 2018. Eighty-three percent (\$898) million of this amount funded the full risk-based contracts signed by Amerigroup, AmeriHealth, and Trusted, while approximately 17 percent (\$179 million) funded the risk sharing contract with HSCSN.

Notes:

1. In 2017, DHCF awarded contracts for the upcoming FY18 contract year for the three full risk-based MCOs. Two of the three MCOs -- AmeriHealth and Trusted -- are returning MCOs, with one newly-awarded MCO as of October 2017 - Amerigroup. DHCF released a Managed Care RFP for a new 5-year contract starting in 2019.
2. Total Capitation Revenue excluding HIPF payments and DC Exchange/Premium tax revenue based on the MLR letters and calculations provided by the MCOs. For HSCSN, capitation revenue excludes DC Exchange/Premium tax revenue and Risk Share.

History of The MCO Performance Review

- ❑ Following the award of the contracts for the three full risk-based plans in 2013, DHCF initiated the MCO performance review process as the first step towards reforming a troubled program.
- ❑ Prior to this award, DHCF's MCO program was hampered by ambiguous contract language, financially unstable providers, and de minimis reporting requirements that made it difficult to assess the performance of the plans.
- ❑ Accordingly, to coincide with the new five-year MCO contracts, DHCF initiated the comprehensive review process in 2014 to assess and evaluate the performance of its three full risk-based MCOs.
- ❑ In 2016, DHCF included the Child and Adolescent Supplemental Security Income Program, managed by HSCSN, as part of the MCO performance review.

Goals Of The Performance Review

❑ There are three primary goals of this performance review:

1. Evaluate the degree to which DHCF's risk-based MCOs and the single risk sharing plan successfully ensure beneficiary access to an adequate network of providers while managing the appropriate utilization of health care services.
2. Provide objective data on the performance of the MCOs across a number of domains to inform decision making about possible policy changes for the managed care program.
3. Facilitate an assessment of each MCO to help guide oversight activities and prioritize areas for enhanced monitoring and corrective action.

Focus Of The Performance Review

- ❑ This annual report for 2018 addresses the following questions for each MCO:
 - What was the financial condition of the MCOs during 2018? Were the MCO revenues sufficient to cover claims and operating costs?
 - Did the MCOs successfully execute the administrative responsibilities required of a managed care plan – timely claims processing, robust member encounter systems, and appropriate use of claims denial procedures?
 - Did the full risk-based MCOs successfully meet the 85 percent Medical Loss Ratio (MLR) threshold while otherwise containing cost? What service levels were achieved for primary care visits as well as mental health penetration rates for children and adults?
 - As a risk-sharing plan, did HSCSN meet the MLR target established to anchor HSCSN's rates while otherwise containing cost? As a result what is the financial impact for DHCF?
 - What success -- as measured by performance against three established benchmarks -- did the full-risk MCOs experience in coordinating care for its members in 2018?

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Summary Of Key Findings

Troubling Financial Conditions For Largest MCO - Full Risk-Based MCOs

- ❑ Two of the three full-risk MCOs are in good financial condition for 2018. Each of the full risk-based MCOs reported risk-based capital (RBC) positions that are above the required level of 200 percent. While two of the MCOs posted profits ranging from 4 to 30 percent with ample reserves to meet incurred but unreported claims with liquid assets, these two MCOs fell short of the threshold for premium spent on medical and quality improvement costs which DHCF will further review to identify the underlying causes. Conversely, AmeriHealth was an exception - posting operating losses and a sharp decline in capital in 2018.

AmeriHealth's Low Margins

- AmeriHealth continued to experience double-digit growth in both net claims and total average monthly enrollment in 2018, when compared to 2017. The shift in population and increased medical cost observed in 2018 are indicative of adverse selection, and appear to correlate with the transition of a high-cost, high-acuity portion of the MedStar population to AmeriHealth over the 2018 review period. This has culminated in both operating losses and risk to the financial solvency of the MCO.

Summary Of Key Findings

(continued)

Amerigroup's High Margins

- Given Amerigroup's limited claims experience since convening operations with the District in October 2017, Amerigroup employed a conservative loss ratio approach in 2017 to derive incurred but not reported (IBNR) claims expense for the period. During 2018, Amerigroup's average monthly claims expenses were lower than forecasted, coupled with the MCO releasing reserves and reversing previously accrued liabilities and expenses for estimated claims, leading to increased margins for the MCO as of December 2018.

HSCSN's Improving Financial Position

- After suffering operating losses and reporting inadequate solvency levels in 2017, HSCSN's financial position has improved in 2018. The District required HSCSN to create an RBC improvement plan in early 2018 to improve the MCO's solvency to acceptable levels. Since implementation of the improvement plan, HSCSN's total adjusted capital has increased 101 percent, resulting in a RBC of 283 percent which is above the District's minimum requirement for solvency levels. In addition, HSCSN is operating at a gain for 2018 due to double-digit reductions in inpatient costs, which the MCO reports are driven by declining trends in utilization of the newborn intensive care unit (NICU) for less than one year old segment of the MCO's population. HSCSN's reported cash position is lower than prior periods; however, this was primarily driven by a change in methodology for calculating the MCO's cash and cash equivalents. DHCF continues to closely monitor the MCO's operational and financial performance.

Summary Of Key Findings

(continued)

Administrative Performance - All Health Plans

- ❑ Four areas are typically evaluated to assess MCOs' administrative performance – adequacy of provider network, timely payment of claims, appropriate management of the claims adjudication process, and successful execution of an encounter system. Data from this analysis indicates the MCOs are, on balance, properly managing these significant responsibilities, with one notable concern. Specifically, in 2018:
 - The MCOs have maintained comprehensive and diverse provider networks to ensure access to a full range of services as well as robust systems to report patient encounters.
 - All of the MCOs exceeded the District's timely payment requirement in 2018, ensuring the continuity of operations for their contracting providers.
 - District MCO's overall claims denial rate was five percent, which is consistent with prior rates. However, nearly 11 percent of claims initially denied were later overturned – an unnecessary inefficiency in the claims management process. Amerigroup had the highest denied claims later overturned; however, this was primarily the result of provider billing issues identified during Amerigroup's first year of operations, which the MCO is working directly with the providers to educate on proper billing practices. Trusted had the second highest denied claims later overturned, driven primarily by lack of required referring NPIs on specialist claims or prior authorizations which Trusted allowed providers to correct and resubmit.

Summary Of Key Findings

(continued)

Medical Expenses - All Health Plans

- ❑ Only one of the three full-risk MCOs spent at least the required 85 percent of MCO revenue on beneficiary Medicaid and Alliance medical expenses while generally avoiding spikes in their per-member, per-month (PMPM) costs. Amerigroup fell short of this requirement, due to lower than expected average monthly claims and release of prior period reserves. Trusted also fell short of this requirement, due primarily to loss of a contract with George Washington Hospital, coupled with a noticeable decrease in high-cost utilizers of services from 2017 to 2018. Overall, the expense growth rate from 2017 to 2018 for Medicaid adults was relatively flat at two percent growth while the cost for children decreased roughly three percent.
- ❑ The PMPM cost of the Alliance program grew by 13 percent, driven primarily by AmeriHealth's 38 percent growth in PMPM expenses primarily in inpatient, outpatient, and pharmacy services. AmeriHealth attributes the increase in pharmacy spend due to both pharmacy cost and utilization increases for specialty drugs. Conversely, the other full-risk plan* experienced reductions in PMPM costs, further supporting the transition of a high-cost, high-acuity portion of the MedStar population to AmeriHealth in 2018. Although, the growth rate for the Alliance population in 2018 has appeared to slow from the high of 31 percent in 2017; however, the inherent short runout period for this analysis results in a high degree of uncertainty for reported reserve estimates.
- ❑ Historically, the growth in Alliance spending was fueled by DHCF's need to transition the pharmacy spending for the program off of the Department Of Defense Discount Program and into the MCO benefits in 2016. While enrollment growth is stable, the Alliance population is becoming slightly older with more complex medical problems. This has driven increased spending in pharmacy, outpatient and inpatient hospital costs.
- ❑ HSCSN's 88 percent spending level on medical expenses for 2018 aligned with the threshold which provides the anchor for its rate. This afforded the MCO modest operating margins for the year, and mitigated the need for risk corridor payments in 2018. The plan observed an overall six percent reduction in medical costs for the year; however, the limited population and high- acuity membership subject the MCO to increased volatility in costs which DHCF mitigates via risk-sharing arrangements tied to the MCO's annual profits and losses.

Summary Of Key Findings

(continued)

Mental Health Service Utilization

- ❑ The outpatient mental health MCO beneficiary utilization rates for 2018 were stable compared to 2017, with a slight increase for adults. For MCO-enrolled children, there was a slight decrease in utilization of outpatient mental health rehabilitative services (MHRS) for children with serious mental illness. This may be due to two factors: (1) Closure of several MHRS providers that transitioned out of the network in 2017. Although new providers have been certified and patients have been reassigned, some patients may not yet be utilizing the new sites as often. (2) Lack of clarity regarding entry points for behavioral health services and MCO's coverage of low-acuity behavioral health services, which may have led to some Medicaid beneficiaries to instead rely on MHRS or locally covered benefits for access to behavioral health care.
- ❑ Total MCO spending on behavioral health services increased 7 percent and 13 percent PMPM for Medicaid adults and children from 2017 to 2018. Additionally, the District has observed consistent growth in PMPM spend on MCO behavioral health services over the past five years.

Physician Visit Rates

- ❑ On average, MCO-enrolled children's physician visit rates and well-child visits (WCV) decreased in 2018 for nearly all plans except for Amerigroup, which had stable physician visit rates and a slightly increased WCV. Amerigroup anticipated that newly implemented medical record review processes would improve rates, and its physician visit rates may reflect that. AmeriHealth observed continuous influx of enrollment throughout 2018, which impacted the denominator and consequently reduced their overall visit rates. Trusted attributes the decline in well-child visits to a loss in eligible membership; while HSCSN's results increased in Q3 due to seasonality of services though ended up lower for the year compared to 2017 due to a reduction in eligible members. DHCF will work with the MCOs, pediatric providers and agency stakeholders to continue to increase awareness of the importance of periodic preventative visits for all Medicaid beneficiaries.
- ❑ MCO-enrolled adult physician visit rates were either stable or decreased for nearly all plans in 2018, except for AmeriHealth, which experienced an increase in adult physician rates for their members.

Summary Of Key Findings

(continued)

Care Coordination

- ❑ The care coordination challenges that plagued the District's three full-risk MCOs from 2014 through 2016 have been well documented -- members' use of the emergency room for routine care, the repeated occurrences of potentially avoidable hospital admissions, the problem of hospital readmissions – and remain stubborn challenges, but with some improvement.
- ❑ For the most recent annual data period for 2018, the MCOs have spent approximately \$47 million on patient care that may have been avoided through the use of more aggressive care coordination strategies. These amounts are in line with FY2017 reported results; however, the MCOs have opportunities for improvement in implementing effective care coordination interventions in the future.
- ❑ With CMS approval, DHCF implemented the MCO pay-for-performance (P4P) program in 2017. When comparing FY2018 results to the baseline targets, Trusted successfully met all requirements for full return of their capitation withhold, and AmeriHealth successfully met at least minimum standards on all three performance goals to earn partial payment of their capitation withhold. Amerigroup, however, did not meet at least minimum standards on all three performance metrics, resulting in loss of their full withhold amount.
- ❑ DHCF postponed the P4P in FY2019 due to changes in the payment rates for the MCOs.

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There Are Several Key Metrics That Speak To The Financial Health Of MCOs

❑ DHCF focuses on four key metrics when evaluating the financial stability of MCOs:

- Medical loss ratio (MLR) – represents the portion of total revenue used by the MCOs to fund medical expenses, including expenses for cost containment.
- Administrative loss ratio (ALR) – represents the portion of total revenue used by the MCOs to fund both claims processing and general administrative expenses.
- Operating Margin (OM) – also referred to as profit margin and is defined as the sum of MLR and ALR subtracted from 100 percent. A positive OM indicates a financial gain while a negative indicates a loss. Mercer's benchmark of the operating margin needed to sustain a strong financial position is approximately 2-4 percent annually over a 3-5 year time horizon.
- Risk-based Capital (RBC) – represents a measure of the financial solvency of managed care plans and reflects the proportion of the required minimum capital that is maintained by a managed care plan as of the annual filing.

Generally, Observed Differences In Health Plan Operating Margins Can Be Traced To A Few Key Factors

- ❑ Assuming adequacy in the base capitated payment rate, there are typically three important factors that impact whether an MCO will experience positive operating margins:
 - **Risk-adjusted payment rates.** Risk adjustment ensures financial viability and operational sustainability for MCOs whose membership represent a disproportionate share of high-acuity, high-cost beneficiaries. With DHCF's payment model, MCOs whose enrollees evince greater medical risk in the form of disease prevalence, receive higher risk scores and greater payments. MCOs with lower risk enrollees receive reduced rates. Thus, plans that properly align membership risk and utilization can gain a considerable advantage over others that do not. For the 2018 contract year, risk adjustment was not implemented though DHCF may consider returning to risk adjustment in future contract years.
 - **Provider contract rates.** Plans that negotiate contract rates that are adequate to build a solid network but lower than their competitors can realize significantly higher surpluses.
 - **Patient utilization management.** Relative differences across plans in the degree to which their enrollees unnecessarily access high end care as an alternative to less expensive treatment will drive variations in operating margins.

Some Strategies Can Increase Operating Margins But Are Not Reflective Of A Properly Operated Health Plan

- ❑ Traditional concerns that patient care is being sacrificed are often expressed when MCOs report significant operating margins. Accordingly:
 - DHCF routinely tracks the MCOs' performance against the 85 percent Medical Loss Ratio (MLR) requirement for the full risk-based plans and an MLR target established during rate setting for the shared risk plan.
 - MCOs that fall short of this standard face detailed scrutiny and possible financial penalties if warranted.
- ❑ MCOs can also artificially (and temporarily) inflate operating margins by repeatedly denying claims that should be paid.
 - DHCF monitored and reported on the MCOs' management of the denied claims process starting in 2016. This report provides a comparative analysis for the year 2018 and the corresponding period in 2017.

AmeriHealth Continues To Experience An Increase In Enrollment Since The Implementation Of The New Contracts In 2017, Driven By The Decrease In Enrollment From The Other Two Full-Risk MCOs

MCO	Medicaid & Alliance Oct 2017 Enrollment	Medicaid & Alliance December 2018 Enrollment	Net Change (%)
Amerigroup	58,998	46,645	(20.9)
AmeriHealth	110,333	121,411	10
Trusted	37,444	34,145	(8.8)

Source: Department of Health Care Finance Medicaid Management Information System (MMIS).

Payments By DHCF To The MCOs In 2018 Were Not Sufficient To Cover Both Claims And Administrative Cost For All MCOs, As AmeriHealth Reported A Significant Operating Loss For The Year

MCO Revenue and Expense Data for January 2018 to December 2018

Revenue¹

—

Claims²

—

Administrative Cost³

=

Operating
Margin (Loss)

MCO	Revenue	Claims	Administrative Cost	Operating Margin (Loss)
Amerigroup ⁴	\$211.4M	\$134.9M	\$13M	\$63.5M
AmeriHealth	\$534.8M	\$508M	\$47.6M	\$(20.8)M
Trusted	\$151.8M	\$121.5M	\$23.6M	\$6.7M
HSCSN ⁵	\$178.5M	\$157.8M	\$19.3M	\$1.4M

- Notes:
1. Total Capitation Revenue excluding HIPF payments and DC Exchange/Premium tax revenue based on the MLR letters and calculations provided by the MCOs. For HSCSN, capitation revenue excludes DC Exchange/Premium tax revenue and Risk Share.
 2. Total incurred claims (including IBNR) and cost containment expenses as of December 31, 2018, net of reinsurance recoveries.
 3. Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings, excluding cost containment expenses as reported in the DISB and HIPF payments and DC Exchange/Premium taxes as reported in MLR report/calculation provided by the MCOs. For HSCSN, administrative expenses are reported based on MCO submitted balance sheet and income statement.
 4. Amerigroup began contracted services as of October 1, 2017.
 5. HSCSN's financial results are reported in the aggregate. DHCF does not currently segregate HSCSN's financial results for the Special Needs and Well population.

Source: MCO Quarterly Statement filed by the MCOs with the Department of Insurance, Securities, and Banking (DISB) and self reported financials for HSCSN.

Estimated Risk-Based Capital Measures Provide A Reliable Indicator Of MCO Solvency

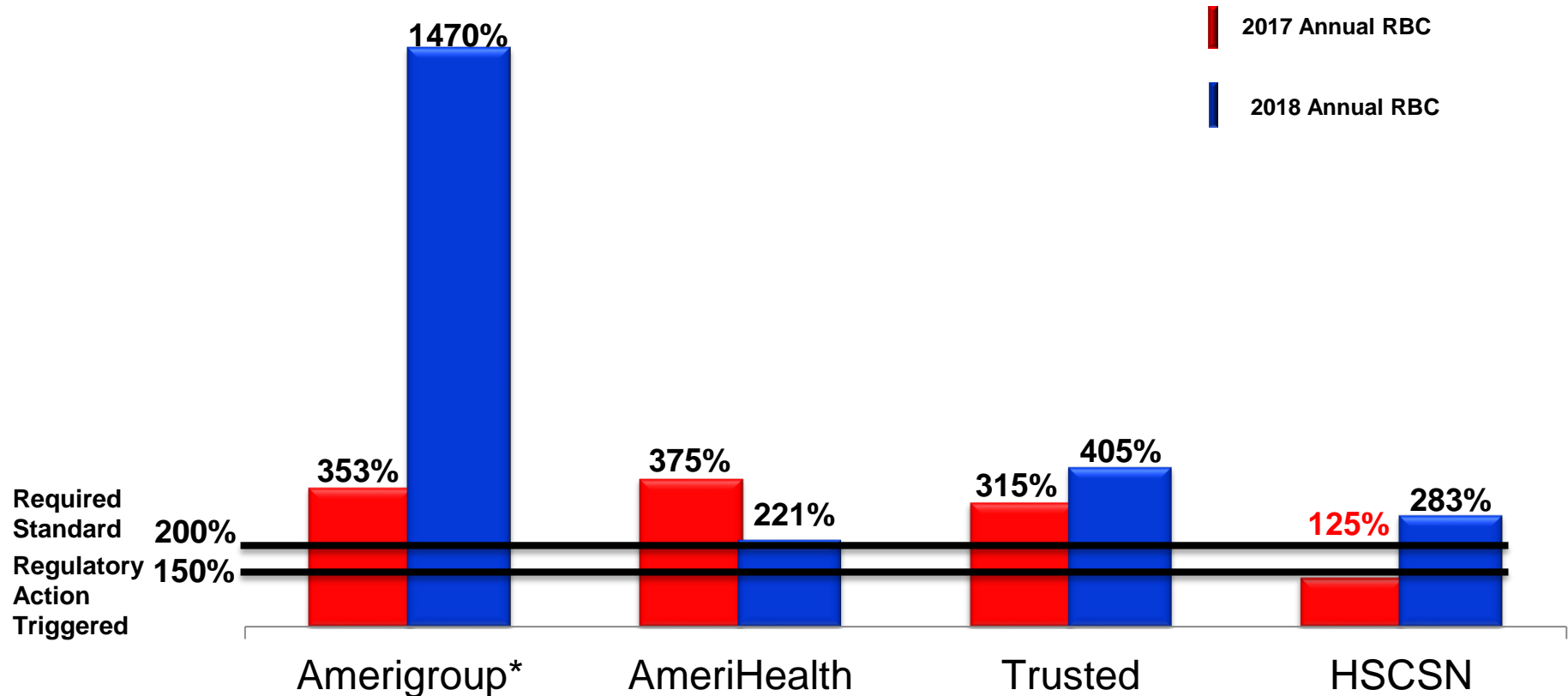
- ❑ The MCO's Risk-based Capital (RBC) levels can be seen as a proxy for whether an MCO has the assets to pay claims.
- ❑ MCOs conduct this complicated calculation annually for each MCO using end-of-year financial data (as well as some information that is not publically disclosed) that is provided to the Department of Insurance, Securities and Banking (DISB) for review.
- ❑ MCOs with RBC levels that fall below 200 percent face greater scrutiny from DISB and DHCF (as described on the next slide) to ensure that they raise their capital level above 200 percent RBC.
- ❑ This report compares the annual RBC measures reported by the MCOs in their official 2017 financial statements filed with DISB to the annual results for 2018.

Regulators Track Insurers Risk-Based Capital Levels And Have Guidelines For Taking Action

- ❑ Based on the level of reported risk, the National Association of Insurance Commissioners indicates that a number of actions (described below) are available if warranted:
 1. **No action** - Total Adjusted Capital of 200 percent or more of Authorized Control Level.
 2. **Company Action Level** - Total Adjusted Capital of 150 to 200 percent of Authorized Control Level. Insurer must prepare a report to the regulator outlining a comprehensive financial plan that identifies the conditions that contributed to the company's financial condition and a corrective action plan.
 3. **Regulatory Action Level** - Total Adjusted Capital of 100 to 150 percent of Authorized Control Level. Company is required to file an action plan and the Insurance Commissioner issues appropriate corrective orders to address the company's financial problems.
 4. **Authorized Control Level** - Total Adjusted Capital 70 to 100 percent of the Authorized Control Level triggers an action in which the regulator takes control of the insurer even though the insurer may technically be solvent.
 5. **Mandatory Control Level** - Total Adjusted Capital of less than 70 percent triggers a Mandatory Control Level that requires the regulator to take steps to place the insurer under control. Most companies that trigger this action level are technically insolvent (liabilities exceed assets).

All Four MCOs Maintained Risk Based Capital Levels That Exceeded Recommended Standards For 2018, With HSCSN Demonstrating Notable Improvement From 2017

Annual 2018 Risk-Based Capital For MCOs Compared To 2017 Annual Level



Note: HSCSN is not subject to DISB Risk-Based Capital reporting requirements. The reported numbers are calculated and included in this report for monitoring and informational purposes.
*Amerigroup began contracted services as of October 1, 2017. Amerigroup's financial results for 2017 represent data from October 2017 through December 2017.

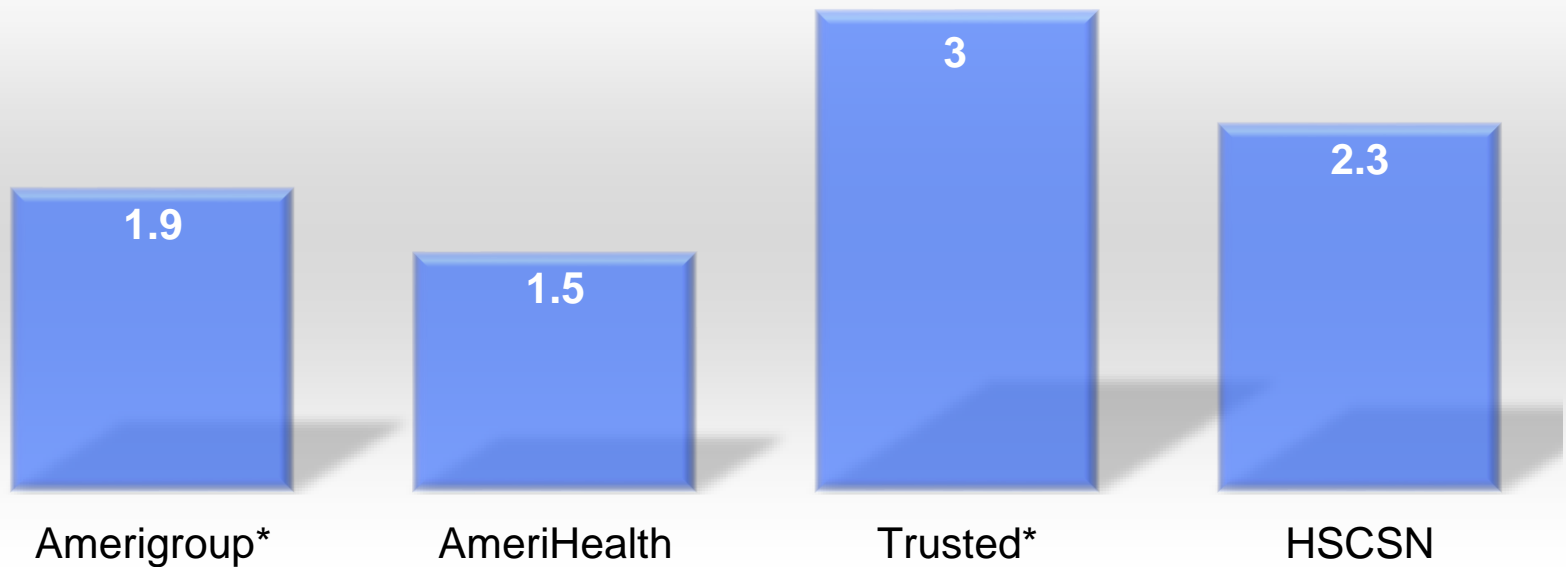
Source: Reported figures are from the MCO's annual 2017 and 2018 financial statements filed with DISB for the full risk MCOs and self reported financials for shared risk MCO.

MCOs Must Maintain Adequate Reserves To Pay “Pipeline” Claims

- ❑ It is paramount in managed care that MCOs maintain a reserve to pay for services that have been provided but not yet reimbursed.
- ❑ This claims liability represents an accrued expense or short-term liability for the MCOs each month and MCOs that fail to build a sufficient reserve may not be able to pay claims when they eventually clear the billing pipeline.
- ❑ Typically, MCOs are expected to retain a reserve equal to between one to two months' worth of claims, depending on how quickly claims are processed.
- ❑ In this report, DHCF reports the reserves MCO's have available to satisfy incurred but not reported claims. This analysis is based on calculations provided by Mercer using data on monthly claim's experience for each plan to calculate the reserves on hand.
- ❑ We also provide an analysis of the number of days the MCOs can operate without accessing long-term assets. This is described as a Defensive Interval Ratio which is, in essence, a liquidity measure -- the degree to which the MCOs can survive on liquid assets without having to make use of either investments from the market or by selling long term assets.

All Four Health Plans Have A Sufficient Number Of Months In Reserve For Estimated Incurred But Not Reported Claims

Estimated Number Of Months Reserves Compared To Average Monthly Incurred Claims For The Period Covering January to December 2018

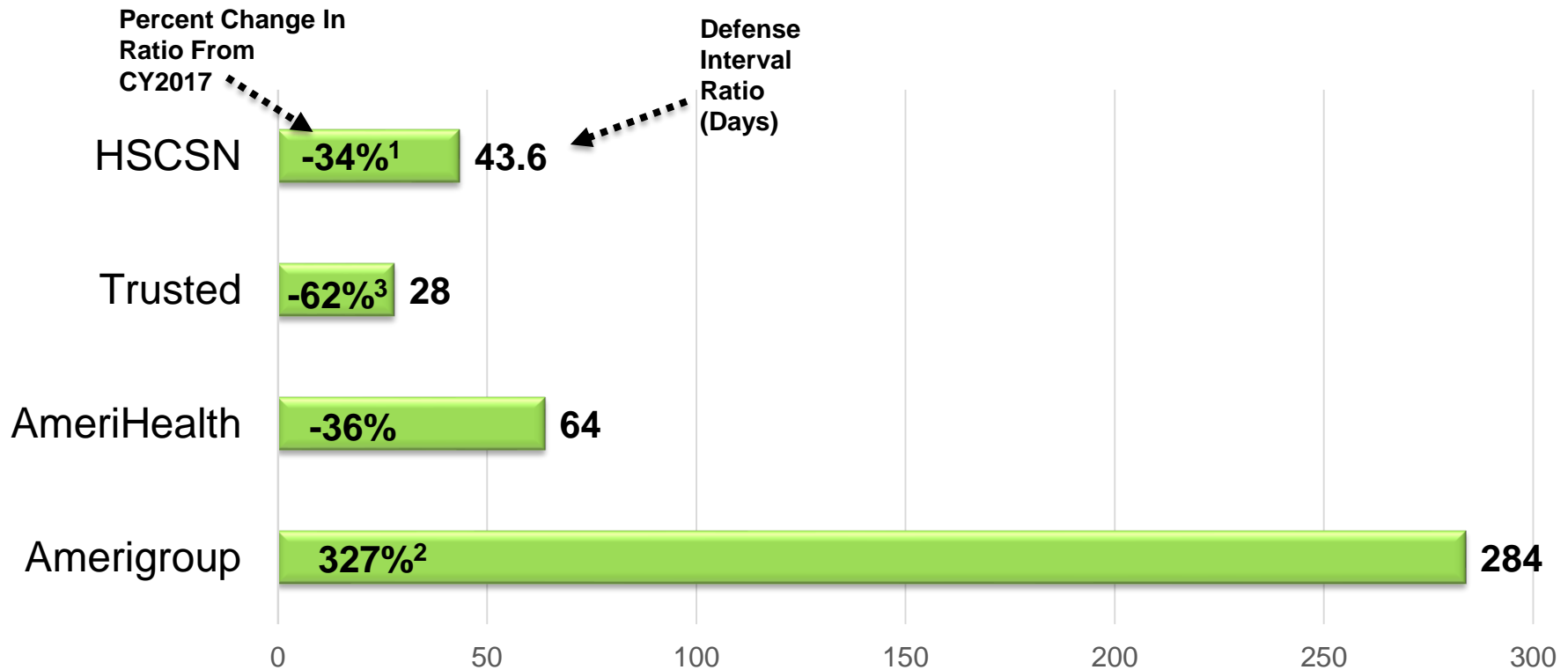


Note: *Amerigroup began contracted services as of October 1, 2017. Amerigroup and Trusted's average monthly claims have declined over the past year leading to above-average results for months in reserve for IBNR. Trusted has a longer claims runout period than the other MCOs, which impacts derived IBNR amounts. The Q4 2018 results rely heavily on IBNR assumptions and final actual results could differ from current estimates.

Source: IBNR is based on amount reported on the MCO's annual filings for the three full risk-based plans and self reported financials for the shared risk plan.

Three Of The Four MCOs Met The Standard Liquidity Benchmark For 2018, While Trusted Reported Maintaining Sufficient Alternative Liquid Investments For Covering Claims

Days In A Year That MCOs Can Operate On Existing Cash Without Having To Access Long-Term Assets For The Period Covering January to December 2018



Note:

1. Prior to 2018, DHCF included intercompany receivables with the parent company, HSC Foundation, to derive HSCSN's Defensive Interval Ratio. Beginning in 2018, DHCF excludes intercompany receivables from HSCSN's cash and equivalents for purposes of deriving HSCSN's Defensive Interval Ratio.
2. Amerigroup began contracted services as of October 1, 2017. All prior year results shown represent 3 months of operation from October 1, 2017 to December 31, 2017.
3. Trusted officials report that the company had a short term investment totaling \$1.2M that matured within 90 days of the annual statement year end date of 12/31/18. Trusted asserts that these investments can be readily converted to cash to pay claims if necessary.

Source: Mercer calculated the Defensive Interval Ratio as cash and cash equivalents divided by daily operating expenses for the period from January to December 2018.

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There Are Several Administrative Requirements Which Are Critical To The Successful Operation Of MCOs

❑ As a part of its core mission, MCOs must accomplish the following:

1. Build an adequate network of providers and pay health care claims to service providers on time and through an electronic claims process with documentation to facilitate reconciliation of payments.
2. Create an accurate electronic record of all patient health care encounters and transmit the files containing this information to DHCF with a minimal error rate.
3. Establish a system of care management and care coordination to identify MCO enrollees with special or chronic health care issues and ensure that these enrollees each receives access to appropriate care, while managing the delivery of health care services for all enrollees.

Contractual Requirements Exist To Ensure Adequate Health Care Provider Networks

- ❑ The five-year MCO contracts contain specific provisions to ensure Medicaid and Alliance enrollees have reasonable access to care. The MCOs must have:
 - 1 primary care physician for every 1,500 enrollees*
 - 1 primary care physician with pediatric training for children through age 20 for every 1,000 enrollees*
 - 1 dentist for every 750 children in their networks*
- ❑ Additionally plan networks must include:
 - At least 2 hospitals that specialize in pediatric care
 - Department of Behavioral Health core service agencies
 - Laboratories within 30 minutes travel time from the enrollees' residence
- ❑ For pharmacies, each plan must have:
 - 2 pharmacies within 2 miles of the enrollees' residence
 - 1 24-hour, seven (7) day per week pharmacy
 - 1 pharmacy that provides home delivery service within 4 hours
 - 1 mail order pharmacy

All Three Health Plans Have Impaneled Substantially More Physicians Than Required By Contract Standards

The Number of Providers In The MCO Networks Compared to Contract Requirements, as of December 2018

Health Plan	Primary Care Doctors Required In Network (1:1500)	Primary Care Doctors In The MCO Network	Primary Care Doctors With Pediatric Specialty Required In Network (1:1000)	Doctors With Pediatric Specialty In Network	Dentist For Children Required In Network (1:750)	Dentist For Children In Network
Amerigroup	31	681	16	640	22	425
AmeriHealth	81	605	53	813	71	356
Trusted	25	528	12	861	17	364
HSCSN*	--	702	--	1,434	--	200

Note: *HCSN does not have contractual requirements mandating physician ratios per member.

Source: This information is self reported by the MCOs to the District's Enrollment Broker as of December 30, 2018 and verified by the Department of Health Care Finance through a sampling of providers.

The MCOs Continue To Make Significant Improvements With The Accuracy Of Their Encounter Data Files Submissions

Number of Recorded Encounters And Accuracy Transfer Rate, January 2018 to December 2018

MCO	Average Monthly Enrollment	Total Submitted Encounters*	Accuracy Rate For Encounter Transfers
Amerigroup	44,625	486,230	97%
AmeriHealth	111,345	1,612,115	99%
Trusted	31,993	344,060	95%
HSCSN	5,088	333,530	93%

Note: *Gross count can include originals, voids and resubmissions. Reported numbers are currently abnormally high due to correction and resubmission of historical encounters to support the FQHC Wrap process. The District expects this number to remain higher than normal for one to two more reporting periods.

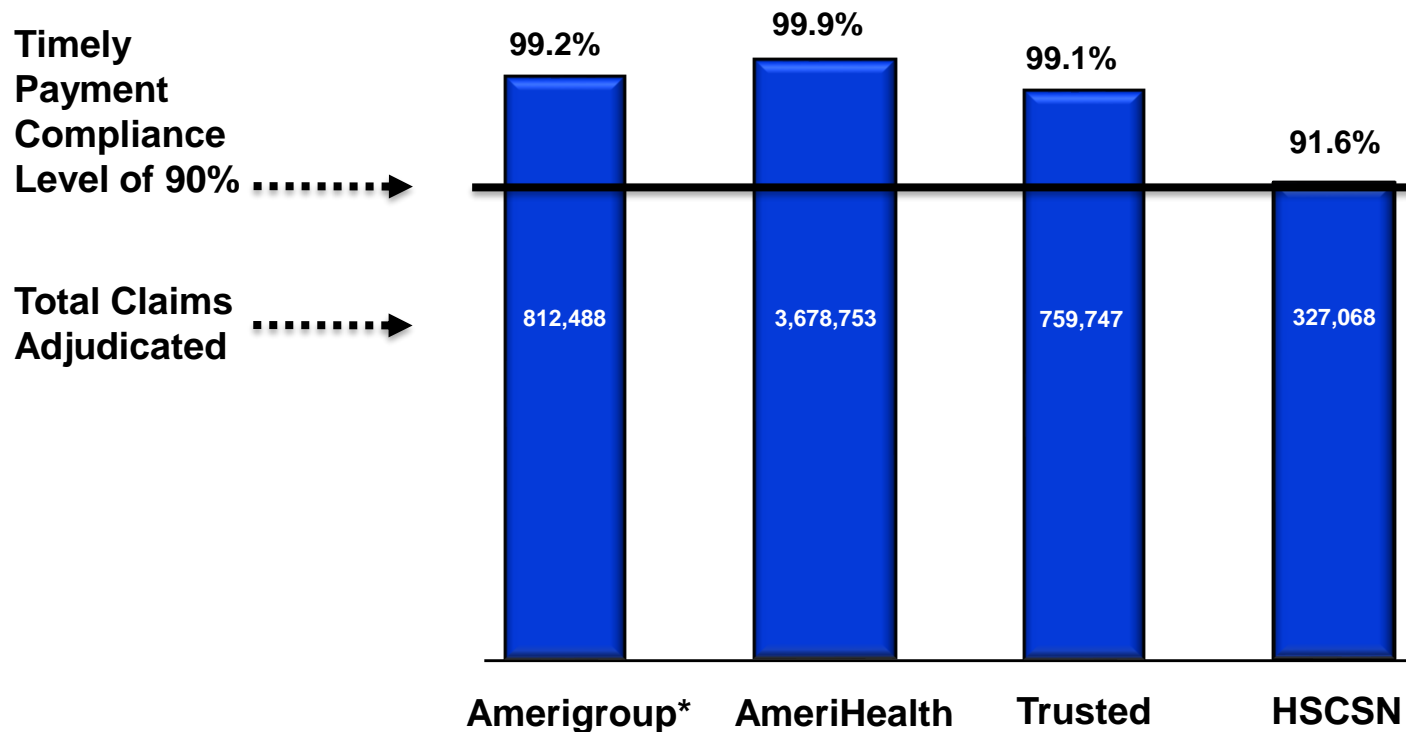
Source: Department of Health Care Finance Medicaid Management Information System as of March 2019.

Timely Payment Of Health Care Claims Is A Core Requirement For The District's Managed Care Plans

- ❑ Claims processing is a central administrative function that MCOs must effectively execute to avoid payment problems for providers.
- ❑ Through electronic claims processing, the District's managed care organizations are required to pay or deny clean claims within 30 days to satisfy timely filing requirements.
- ❑ Like most MCOs, the District's MCOs employ a series of automated edit checks on all claims submitted for payment by healthcare providers in the Medicaid and Alliance programs.
- ❑ Included among the numerous potential problems this system of edit checks is designed to eliminate are:
 - Duplicate or overpayments
 - Payments to out-of-network or otherwise ineligible providers
 - Payments for services delivered to non-eligible patients

Each of the MCOs Exceeded The District's Timely Payment Requirement In 2018

MCO Claims Paid Within 30 Days Based On The District's Timely Payment Requirement, January 2018 to December 2018



Note: *Timely payment of claims for Amerigroup District of Columbia were previously excluded from this analysis due to only having become a District MCO in October 2017. In 2017 DHCF awarded new contracts for the District MCOs for FY18. The 30 day timely payment requirement only applies to "clean claims" that meet the requirement for payment.

Source: Data reported by MCOs on the Department of Health Care Finance's Claims Payment Report.

Claims Adjudication Review Focuses On Whether MCOs Are Acting In Good Faith

- ❑ Because the District's 30-day timely payment requirement does not apply to claims that are initially denied, some providers expressed concern that managed care plans were unjustifiably denying a high rate of claims as a cash management strategy.
- ❑ Such a practice would obviously violate the tenets of good faith claims processing, create significant revenue issues for some of the providers in the MCOs' networks, and potentially cause access to care issues.
- ❑ This report addresses this issue by reporting on the incidence of denied claims in the managed care program and the reasons for the denials for the period covering calendar year 2018. Additionally, outcomes for claims that were initially denied but subsequently approved and repaid are also examined.

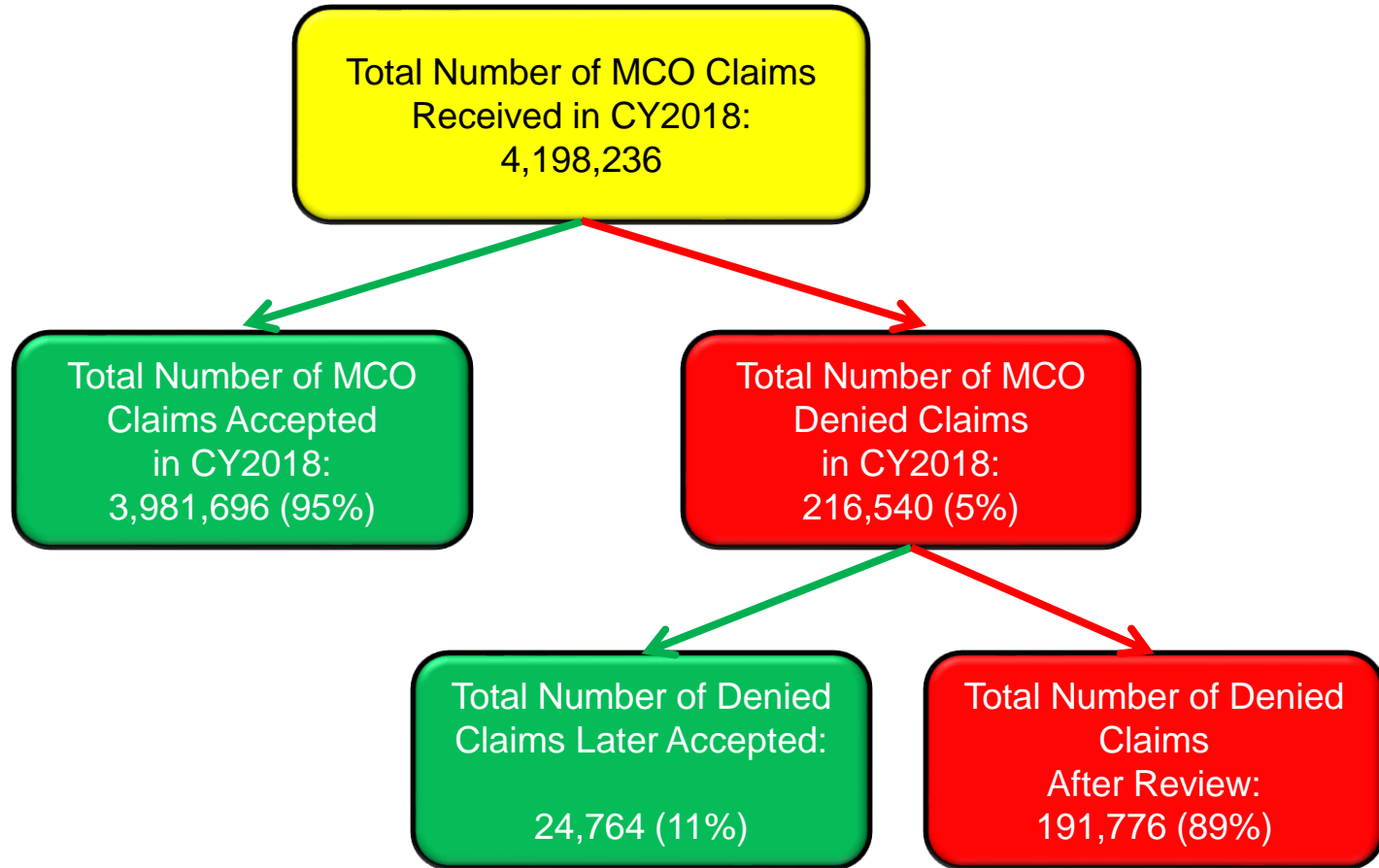
Methodology For Denied Claims Review

❑ The key steps executed for this analysis were as follows:

- First, all MCO denied claims with dates of service between January 1, 2018 and December 30, 2018 were obtained from the District's four MCOs and established as the master dataset. This data extraction yielded nearly 216,985 claims. Due to discrepancies in adjudication practices among the MCO's pharmacy benefit managers (PBMs), denied pharmacy claims were then excluded, yielding a final count of approximately 216,540 denied claims.
- Second, this master dataset was used to categorize provider types to match DHCF naming schemes and search for all claims with missing identifiers.
- Third, using DHCF's MMIS, all paid patient encounters with dates of service between January 1, 2018 and December 31, 2018 were extracted, yielding nearly two million records.
- Fourth, the dataset containing denied MCO claims (Step 1) was then merged with the dataset containing accepted encounters from MMIS (Step 2), using the beneficiaries' Medicaid ID, first date of service, last date of service, and billing provider NPI as the matching variables. This established in the same dataset, claims that were paid, denied, and those that were initially denied but paid at a later date.

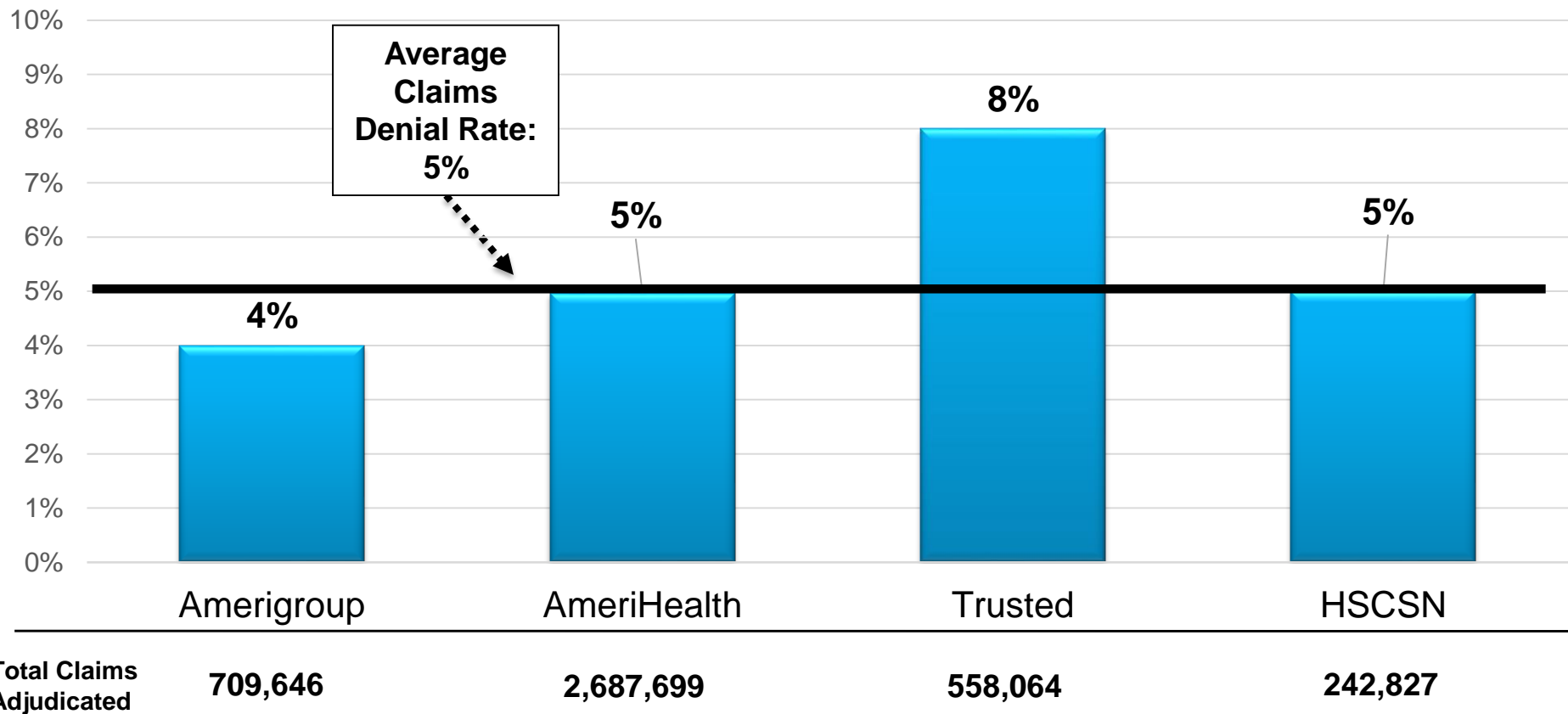
Less Than One Tenth of MCO Claims Were Denied In CY2018

*Total number of denied claims after review represented less than one-tenth of all claims processed



Trusted Denial Rates Were Slightly Above MCO Average

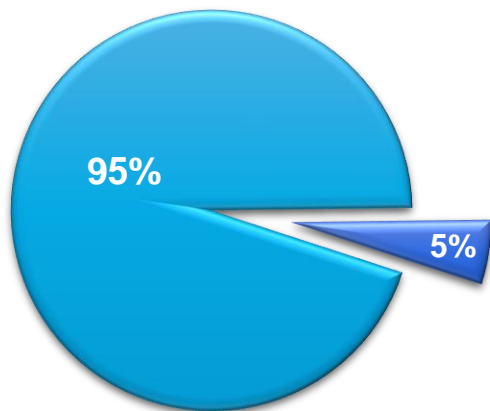
Claims Denial Rates For Each Health Plan, CY2018



MCO Denials Were Mostly Related To Service Coverage And Improper Billing

MCO Claims Denial Rate, CY2018

■ Claims Paid ■ Claims Denied



N = 4,198,236

Four Most Common Denial Reasons	Number of Denied Claims	Percent of Total Denied Claims
Service coverage issue*	101,780	47%
Billing process deficiencies**	36,628	17%
Duplicate claim	28,280	13%
Member not eligible	12,470	6%

N = 216,540 total denied claims**

Notes: *This includes claims missing prior authorization, services not being covered, or exceeded units.

**This includes claims not submitted to primary payor/carrier, or claims with incomplete billing provider information.

Due to discrepancies in adjudication practices among the MCO's pharmacy benefit managers (PBMs), findings exclude denied pharmacy claims

Source: Patient encounters with January 1-December 31, 2018 dates of service from DHCF MMIS system were merged with MCO files containing denied claims for the same period.

DHCF Is Creating a Standardized Provider Manual As Well As Convening Regular Meetings with MCO Provider Relations, To Educate Providers On Proper Eligibility, Service And Billing Requirements

Claims Denial Rate By Top Provider Types, CY2018

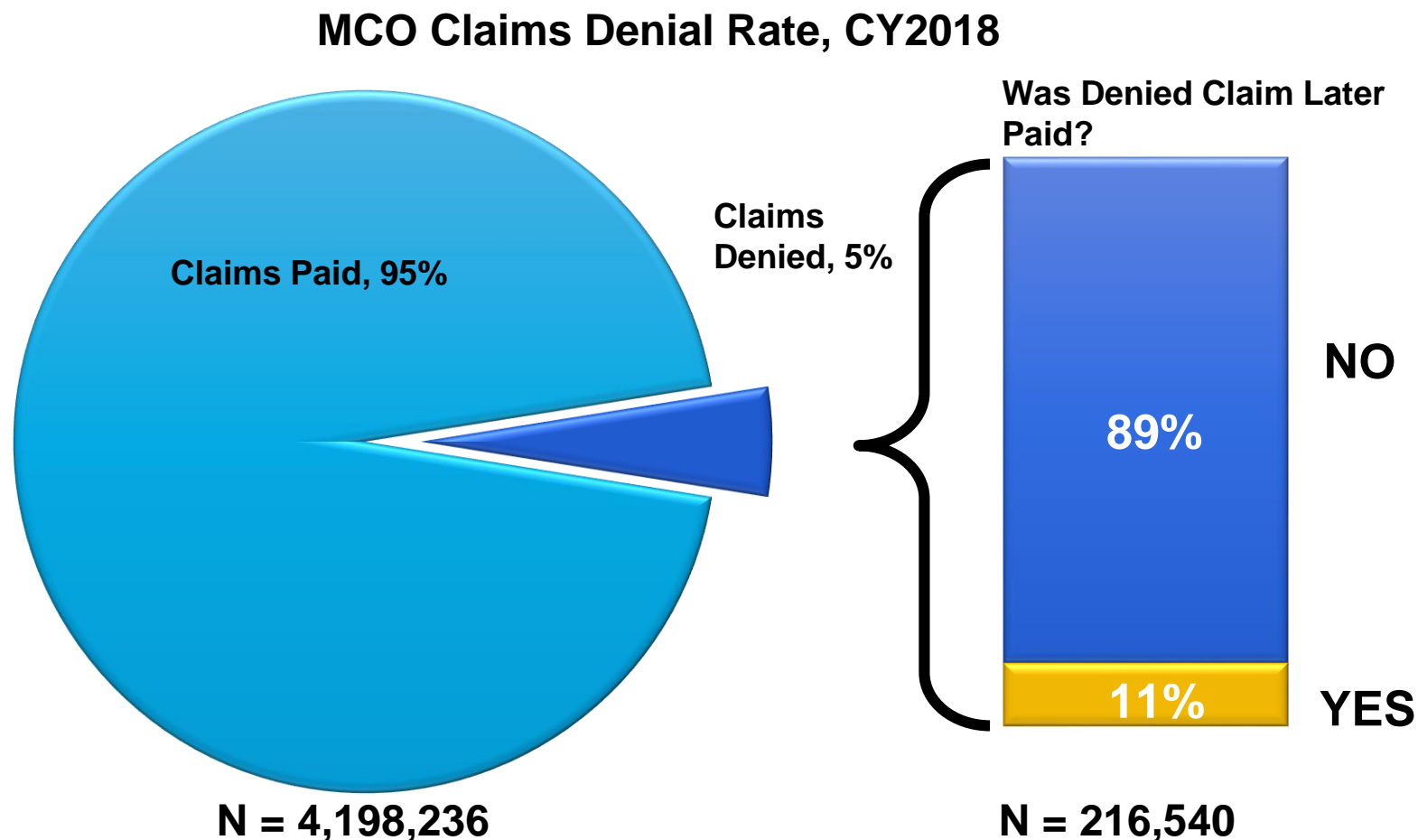
Select Provider Type	Number of Denied Claims	Number of Total Claims	Claims Denial Rate
Nurse Practitioner	5,773	13,907	42%
Community Clinics* (excluding FQHCs)	3,115	17,910	17%
Mental Health Rehabilitation Services (MHRS) providers	2,637	26,508	10%
Free Standing Mental Health Centers	10,263	52,684	19%
Home Health Agency	3,242	19,230	17%

Note: Due to discrepancies in adjudication practices among the MCO's pharmacy benefit managers (PBMs), findings exclude denied pharmacy claims.

*Community Clinics are identified in MMIS as Private Clinics, and typically offer primary care services.

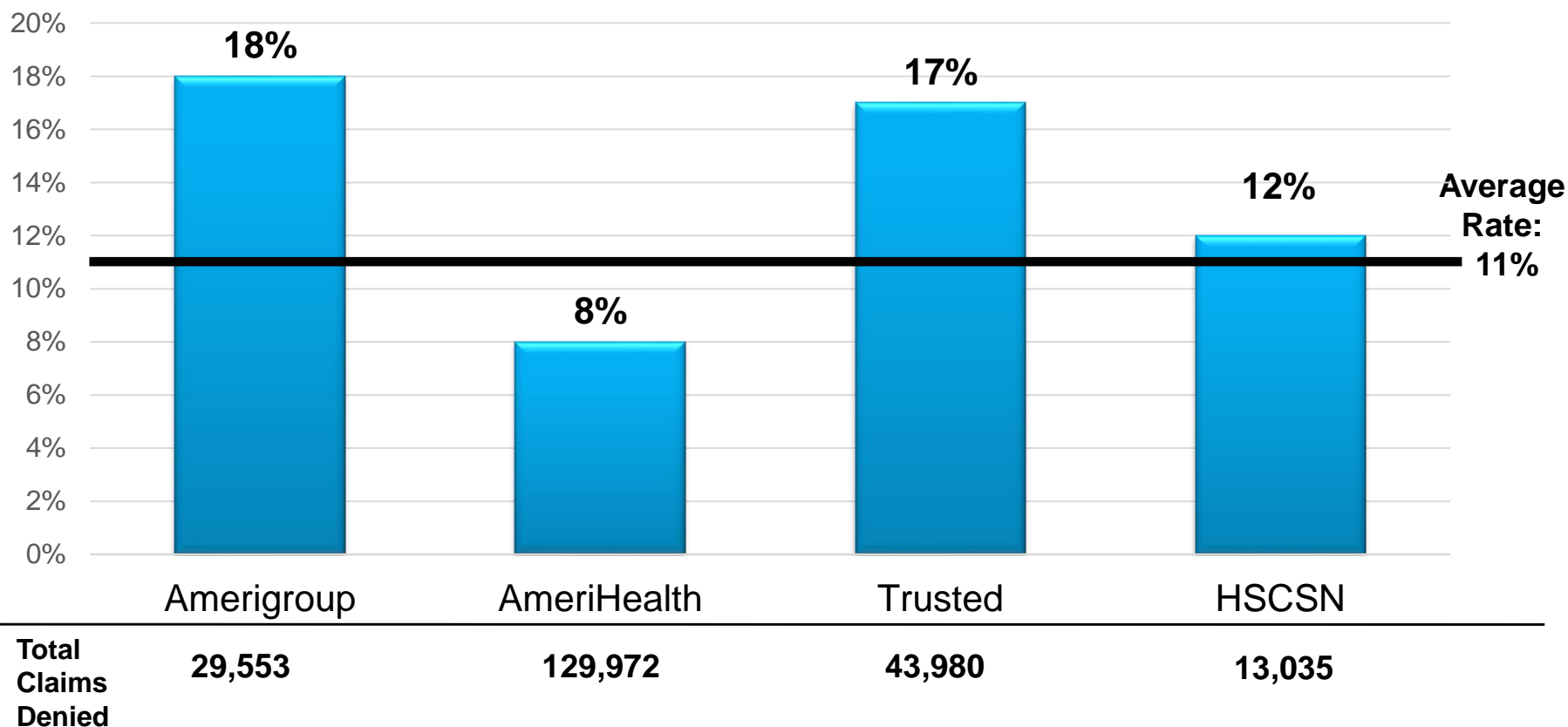
Source: Patient encounters with January 1-December 31, 2018 dates of service from DHCF MMIS system were merged with MCO files containing denied claims for the same period.

Over 10 Percent Of Claims Initially Denied in CY2018 Were Later Overturned And Paid, Consistent with CY2017



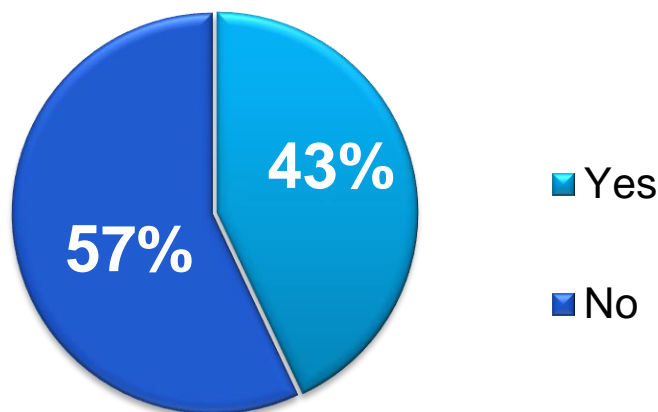
Amerigroup Had The Highest Percentage of Denied Claims Later Overturned

MCO Rates of Payment For Originally Denied Claims, CY2018



More Than 4 Out of 10 Of All Appealed Denied Claims Approved After An Appeal Were Paid Within 30 Days

Percentage Of MCO Claims Approved After Appeal That Were Paid Within 30 Days, CY2018



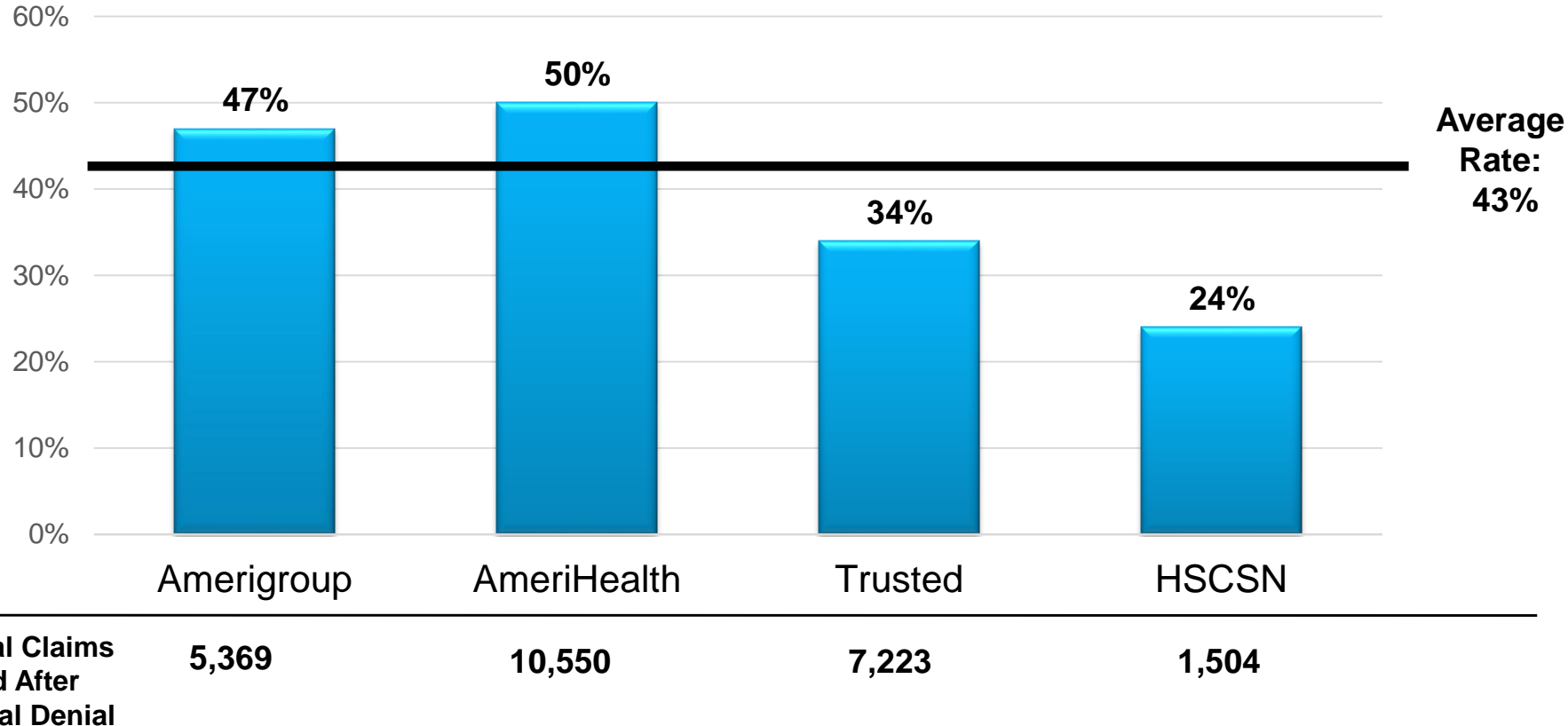
N = 24,764

Note: Due to discrepancies in adjudication practices among the MCO's pharmacy benefit managers (PBMs), findings exclude denied pharmacy claims.

Source: Patient encounters with January 1-December 31, 2018 dates of service from DHCF MMIS system were merged with MCO files containing denied claims for the same period

Payment Of Claims Within 30 Days After Initial Denial Varies By MCO, With Higher Rates For AmeriHealth and Amerigroup

MCO Rates of Payment Within 30 Days For Originally Denied Claims, CY2018



Average Number of Days From Initial Denial to Payment Decreased for Several Provider Types from CY2017 to CY2018

Average Number Of Days To Payment For Appealed Claims, CY2018

Select Provider Types	CY2017	CY2018
Home Health Agencies	113	34
Nurse Midwives	104	47
Psychiatric Residential Treatment Facilities	96	54
Federally Qualified Health Centers	73	56
Free Standing Mental Health Clinics	36	24

Note: Due to discrepancies in adjudication practices among the MCO's pharmacy benefit managers (PBMs), findings exclude denied pharmacy claims.

Source: Patient encounters with January 1-December 31, 2018 dates of service from DHCF MMIS system were merged with MCO files containing denied claims for the same period

Denial Rates Have Decreased By More Than Half Since 2014; Timely Payment of Claims Approved After Initial Denial Has Also Decreased By Almost Half, Warranting Further Review

A Comparison of Outcomes from 2014 – 2018 to date (2014 Paid Claims Exclude Pharmacy)

<u>Outcome</u>	<u>2014</u>	<u>2015</u>	<u>2016</u>	<u>2017</u>	<u>2018</u>
Total Claims Processed	2.26M	4.06M	4.23M	4.1M	4.2M
Claims Denied (%)	18%	14%	12%	8%	5%
Highest Denial Rate By Plan	31% (MedStar)	22% (Trusted)	19% (MedStar)	13% (MedStar)	8% (Trusted)
Denied Claims Later Approved	18%	6%	7%	11%	11%
Denied Claims Later Approved And Paid Within 30 Days	79%	43%	46%	42%	43%

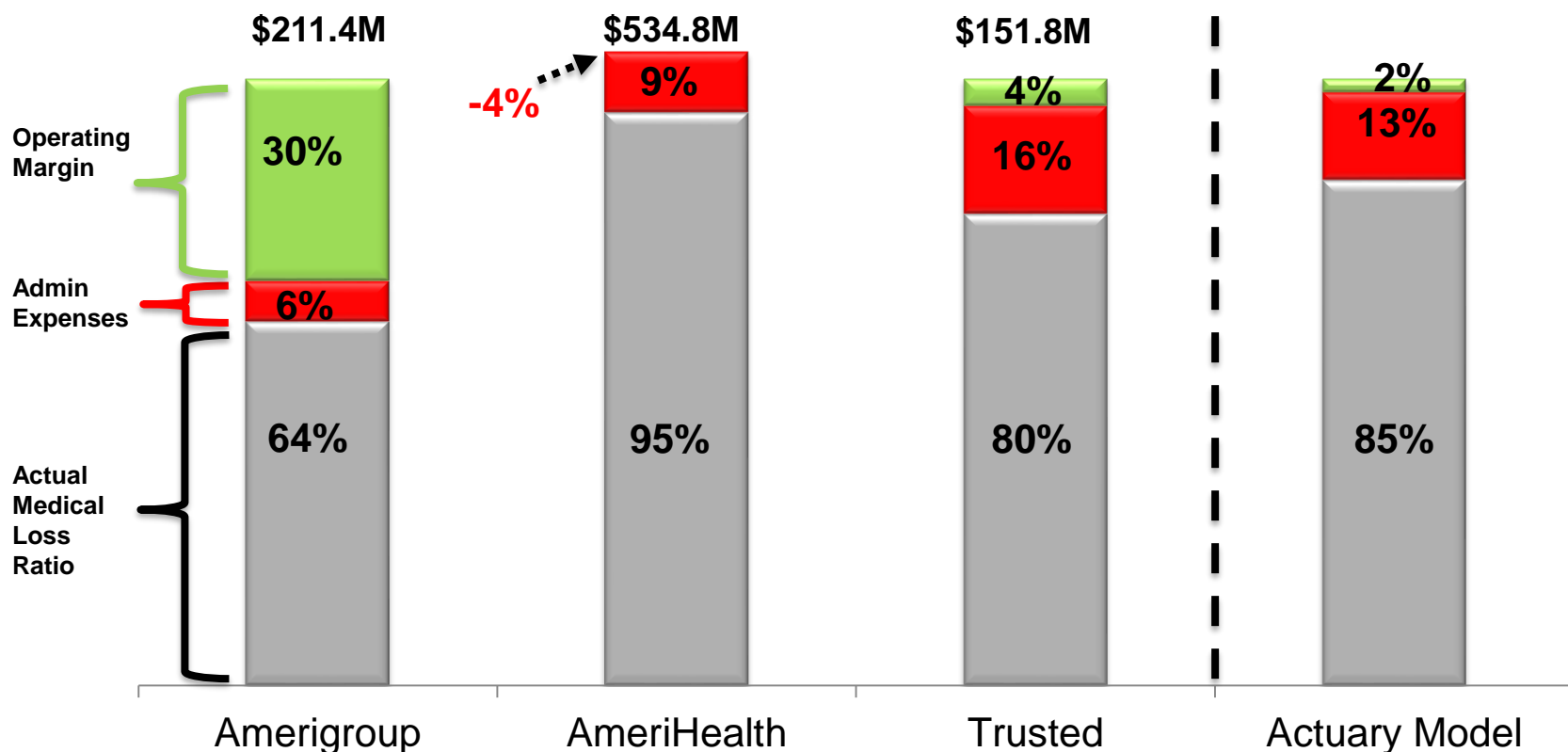
Note: Due to discrepancies in adjudication practices among the MCO's pharmacy benefit managers (PBMs), findings exclude denied pharmacy claims for CY2018.
Source: Patient encounters with January 1-December 31, 2018 dates of service from DHCF MMIS system were merged with MCO files containing denied claims for the same period.

Presentation Outline

- ☐ Goals and Purpose of Managed Care Review
- ☐ Summary Of Key Findings
- ☐ The Financial Performance of the District's Health Plans
- ☐ The Administrative Performance of the District's Health Plans
- ☒ **MCO Medical Spending and Beneficiary Utilization Patterns**
- ☐ Care Coordination and Performance Against Program P4P Benchmarks
- ☐ Conclusions

Only One Full Risk Plan Spent At Least 85 Percent Of Revenue On Member Medical Expenses, While The Other Two Plans Experienced Lower Than Expected Medical Costs For The Year*

Actual MCO Revenue For January 2018 to December 2018



Notes: MCO revenue does not include investment income, HIPF payments, and DC Exchange/Premium tax revenue. Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings and self reported quarterly filings, excluding cost containment expenses, HIPF payments and DC Exchange/Premium taxes as reported in MLR report/calculation provided by the MCOs. Total annual incurred claims (including IBNR) and cost containment expenses as of December 31, 2018, net of reinsurance recoveries. *As Amerigroup began operations in October 2017, limited claims history was used to set initial reserves. This may have resulted in higher reserves than actual claims experience over the reporting period. Trusted experienced a lower than projected claims expense in 2018 most notably due to the loss of a contract with George Washington Hospital, and a restatement of IBNR held for 2017 services.

Source: MCO Annual Statement filed by the MCOs with the Department of Insurance, Securities, and Banking for the three full risk MCOs and self reported Annual Statements for shared risk plan, HSCSN, as of December 2018.

DHCF Has A Risk Sharing Arrangement With HSCSN In Which The Government Shares In The Plan's Profits And Losses

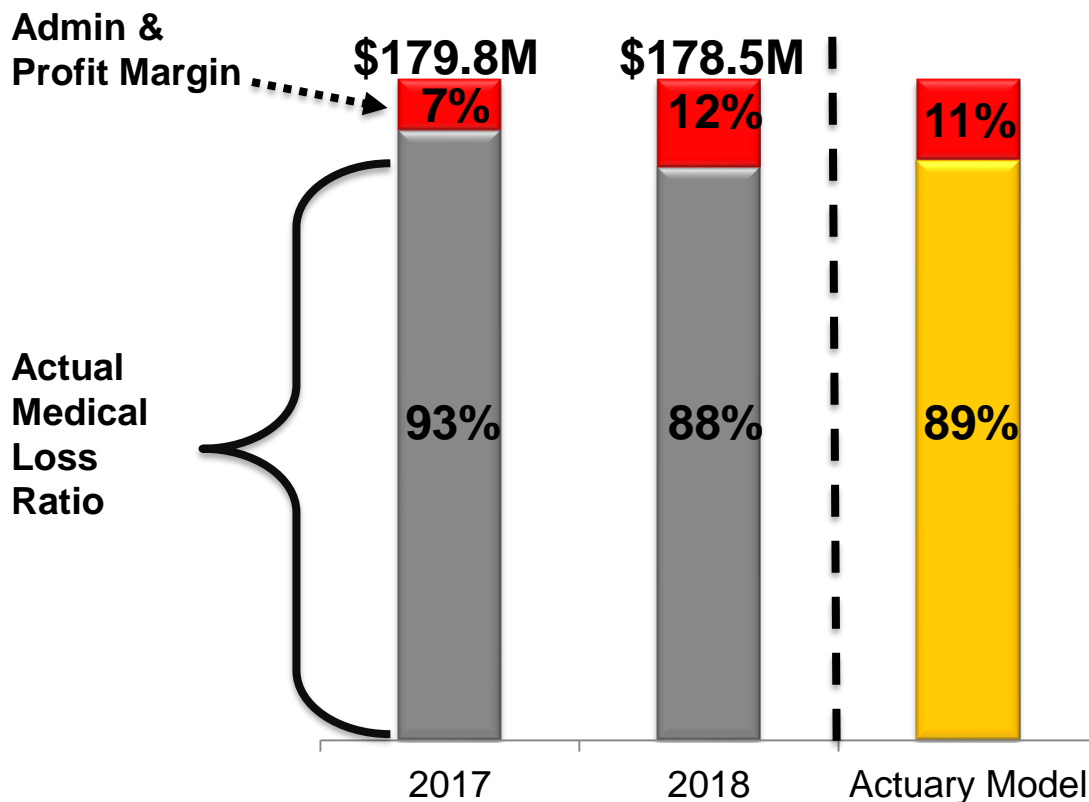
- ❑ DHCF and HSCSN entered into a risk sharing arrangement to limit the financial gains and losses under the contract through the application of risk corridors.
 - The arrangement sets risk corridors around an annual target Medical Loss Ratio established during rate setting. For the current rate setting period, the target MLR is 89 percent and the risk corridor applies to gains and losses of more than two percent. Thus, if the MCO experiences cost below 87 percent, the District shares in the financial gain.
 - Conversely, if HSCSN incurs cost above 91 percent, the District absorbs a portion of the cost.
- ❑ The Table below shows the risk corridors for this contract and how financial gains or losses are shared between the HSCSN and the District:

Risk Corridors*	District's Share	Contractor Share	Corridor Amount Due
<78%	100%	0%	100% to District
>78-87%	50%	50%	50% to District
>87-91%	0%	100%	No payment
>91-100%	50%	50%	50% to MCO
>100%	100%	0%	100% to MCO

- ❑ For 2018, HSCSN's medical expenses as a percent of its revenue (88%) was slightly below the threshold for the Medical Loss Ratio (89%) set during rate development; however, the marginal amount did not trigger the risk sharing provision and no corresponding payment is due to either the MCO or the District for 2018.

HSCSN Spent Slightly Below The 89 Percent Risk Sharing Threshold On The Actuary Model For 2018; However This Amount Did Not Trigger The Risk Sharing Provision

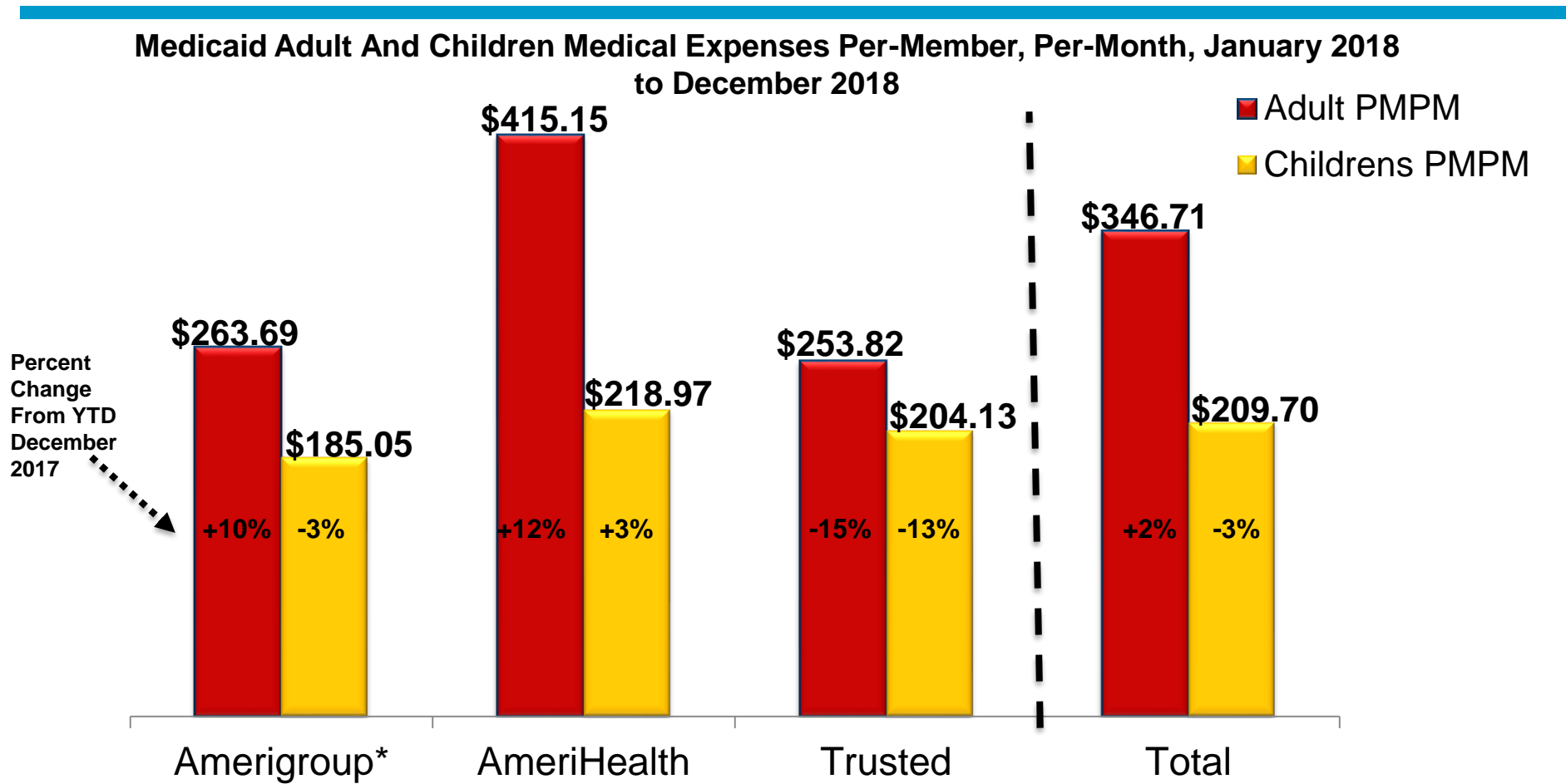
HSCSN Revenue And Claims Cost For YTD December 2017 Compared to YTD December 2018



Risk Share Based on 89% MLR		
	2017	2018
Total (At Risk) or Underspend	\$(6.4M) ²	\$1.07 ²
Amount Due to MCO	\$1.4M ³	\$0 ³
Amount Due to District ¹	-	-
1. Estimated amount of surplus due to the District 2. Estimated amount spent over level (At Risk) or under level (Underspend) set by Medical Loss Ratio 3. Estimated amount payable to MCO based on allocation of at risk amount to District.		

Notes: MCO revenue does not include DC Exchange/Premium Taxes and Risk Share, per the MLR letter and calculations provided by the MCO. Administrative expenses include all claims adjustment expenses as reported in quarterly balance and income statement reports, excluding cost containment expenses and DC Exchange/Premium taxes as reported in the income statement calculation provided by the MCO. Total annual incurred claims (including IBNR) and cost containment expenses as of December 31, 2018, net of reinsurance recoveries. Source: Self reported quarterly statements. HSCSN's financial results are reported in the aggregate. DHCF does not currently segregate HSCSN's financial results for the Special Needs and Well population.

Marginal Increases In Year-Over-Year Medical Expenses For Adults And Marginal Decreases Were Observed For Children In The Medicaid Program, With Growth In Adult Costs Primarily Driven By Rising Trends To AmeriHealth's Population



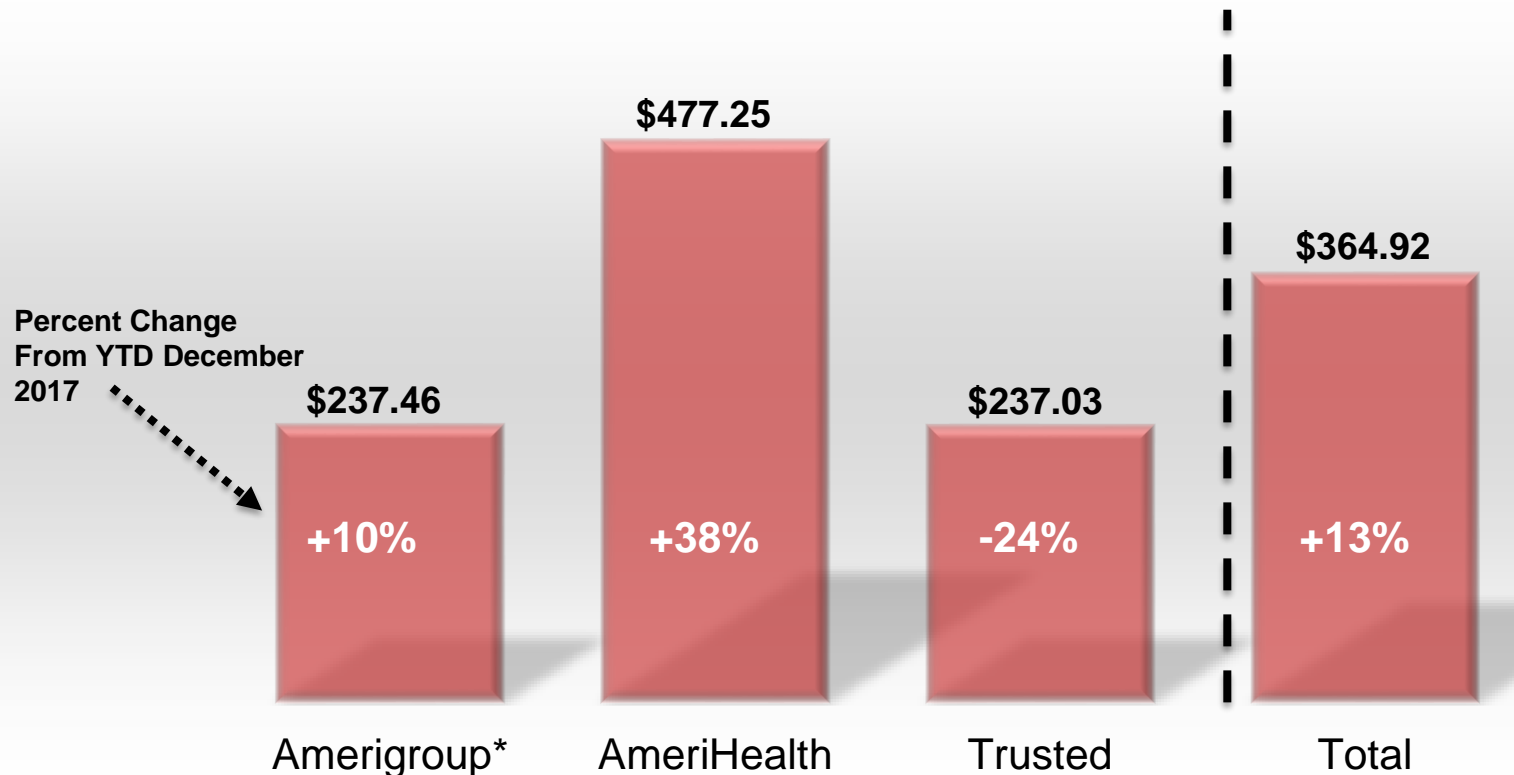
Notes: Incurred from January 1, 2018 to December 31, 2018, paid as of January 31, 2019 for Amerigroup, AmeriHealth and Trusted. Change in average PMPM expense, January 1, 2018 to December 31, 2018 compared to January 1, 2017 to December 31, 2017. *For Amerigroup prior period is October 1, 2017 to December 31, 2017, as Amerigroup began operations in October 2017. IBNR is estimated based on historical payment lags. This short runout period results in a high degree of uncertainty for IBNR estimates and final results will differ. Children defined as person up to age 21 in this analysis for the three full risk MCOs.

Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

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AmeriHealth Experienced Double Digit Growth In Medical Expenses For Alliance, Partly Due To The Transition Of The Pharmacy Cost Into MCO Benefit In 2016, But Primarily Due To The Increased Average Risk Profile Of The Alliance Population And Cost Volatility

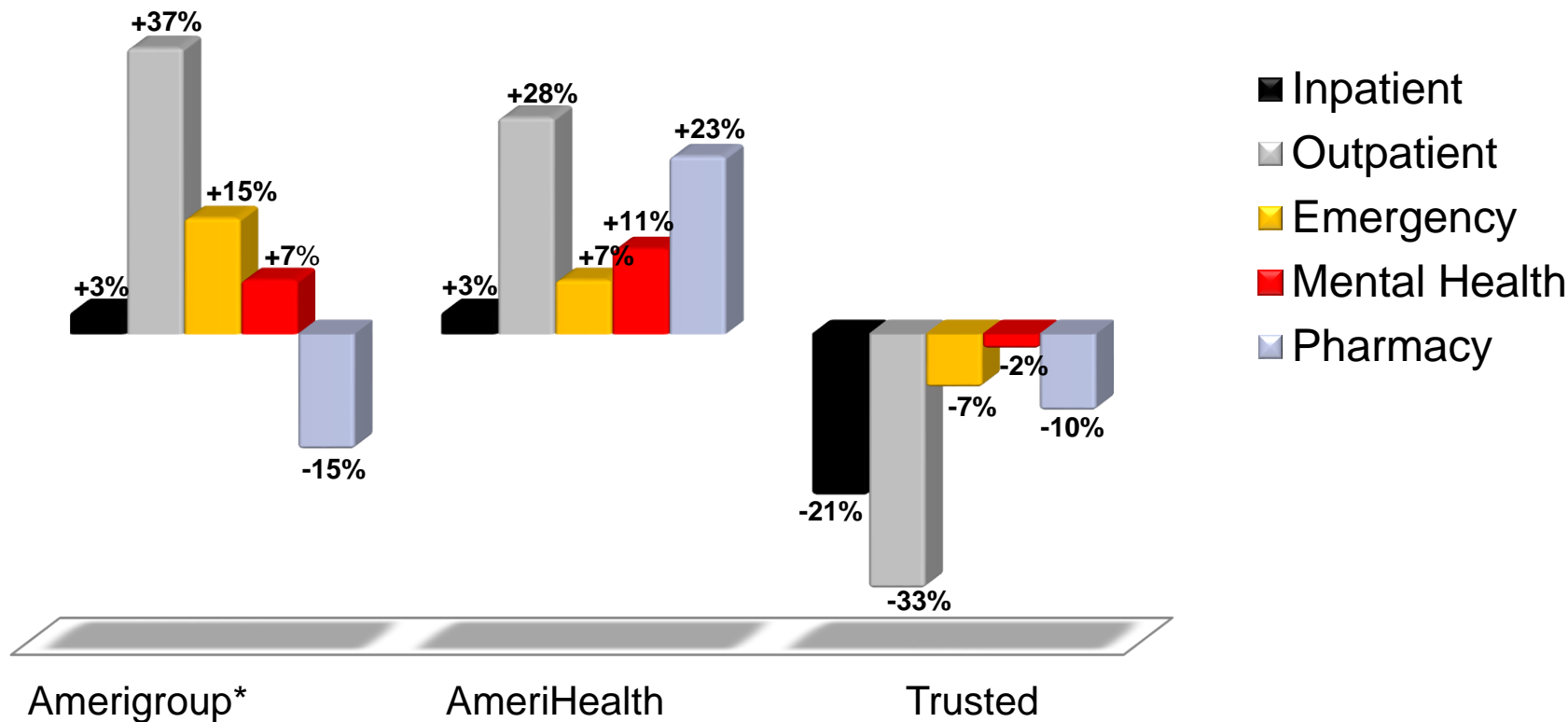
Alliance Adult Medical Expenses Per-Member, Per-Month, January 2018 to December 2018



Notes: Incurred from January 1, 2018 to December 31, 2018, paid as of January 31, 2019 for Amerigroup, AmeriHealth and Trusted. Change in average PMPM expense, January 1, 2018 to December 31, 2018 compared to January 1, 2017 to December 31, 2017. *For Amerigroup prior period is October 1, 2017 to December 31, 2017, as Amerigroup began operations in October 2017. IBNR is estimated based on historical payment lags. This short runout period results in a high degree of uncertainty for IBNR estimates and final results will differ.
Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

For Adults On Medicaid And Compared To The Same Time Period Last Year, AmeriHealth Reported Significant Cost Growth In Many High Cost Categories Of Service, While Trusted Experienced Significant Reductions In Cost For Similar Categories Compared To Last Year

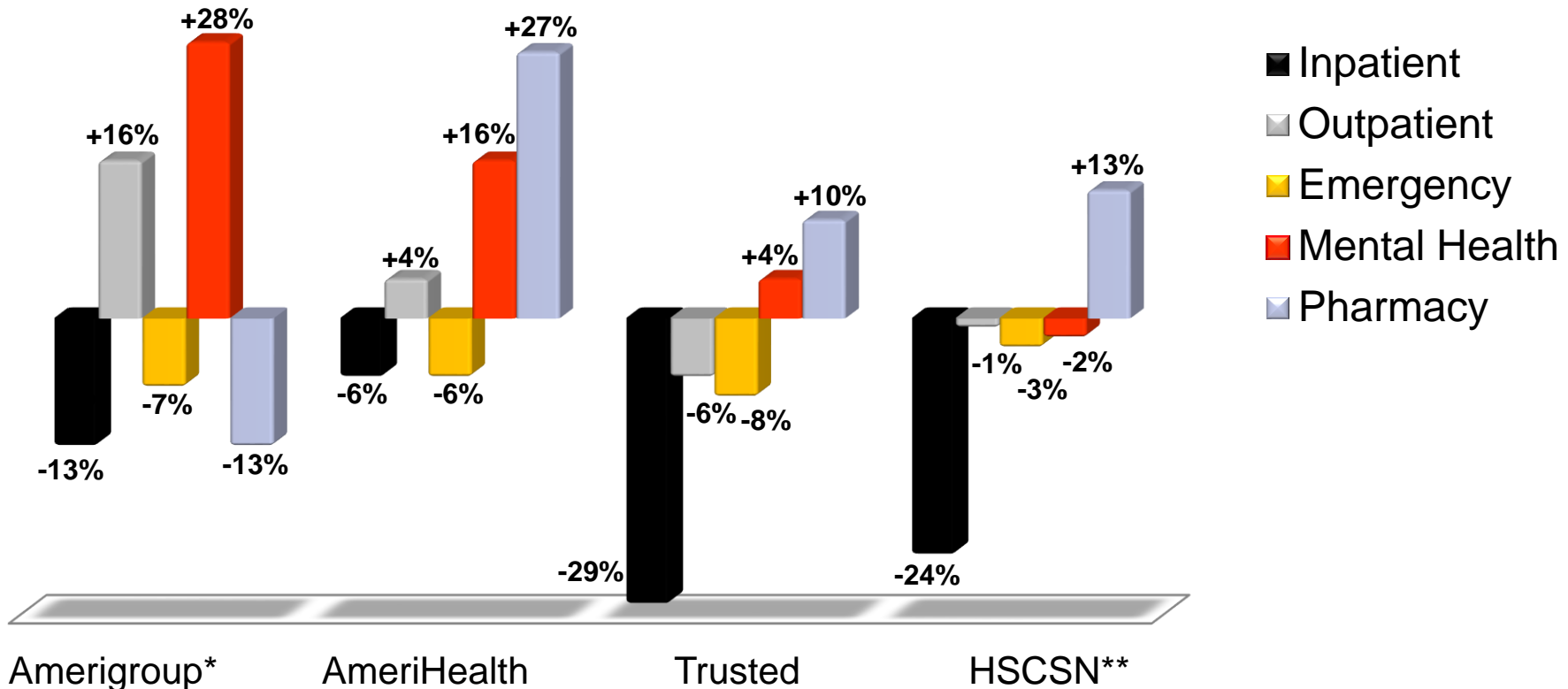
Percent Change in Expenses From YTD December 2017 to YTD December 2018



Note: Change in average PMPM expense, January 1, 2018 through December 31, 2018 compared to January 1, 2017 through December 31, 2017 for AmeriHealth and Trusted. *For Amerigroup prior period is October 1, 2017 to December 31, 2017, as Amerigroup began operations in October 2017.
Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

For Children On Medicaid, As Compared To Prior Periods, All MCOs Reported Notable Reductions In Inpatient And Emergency Costs While AmeriHealth, Trusted And HSCSN Experienced Significant Growth In Pharmacy Expenditures

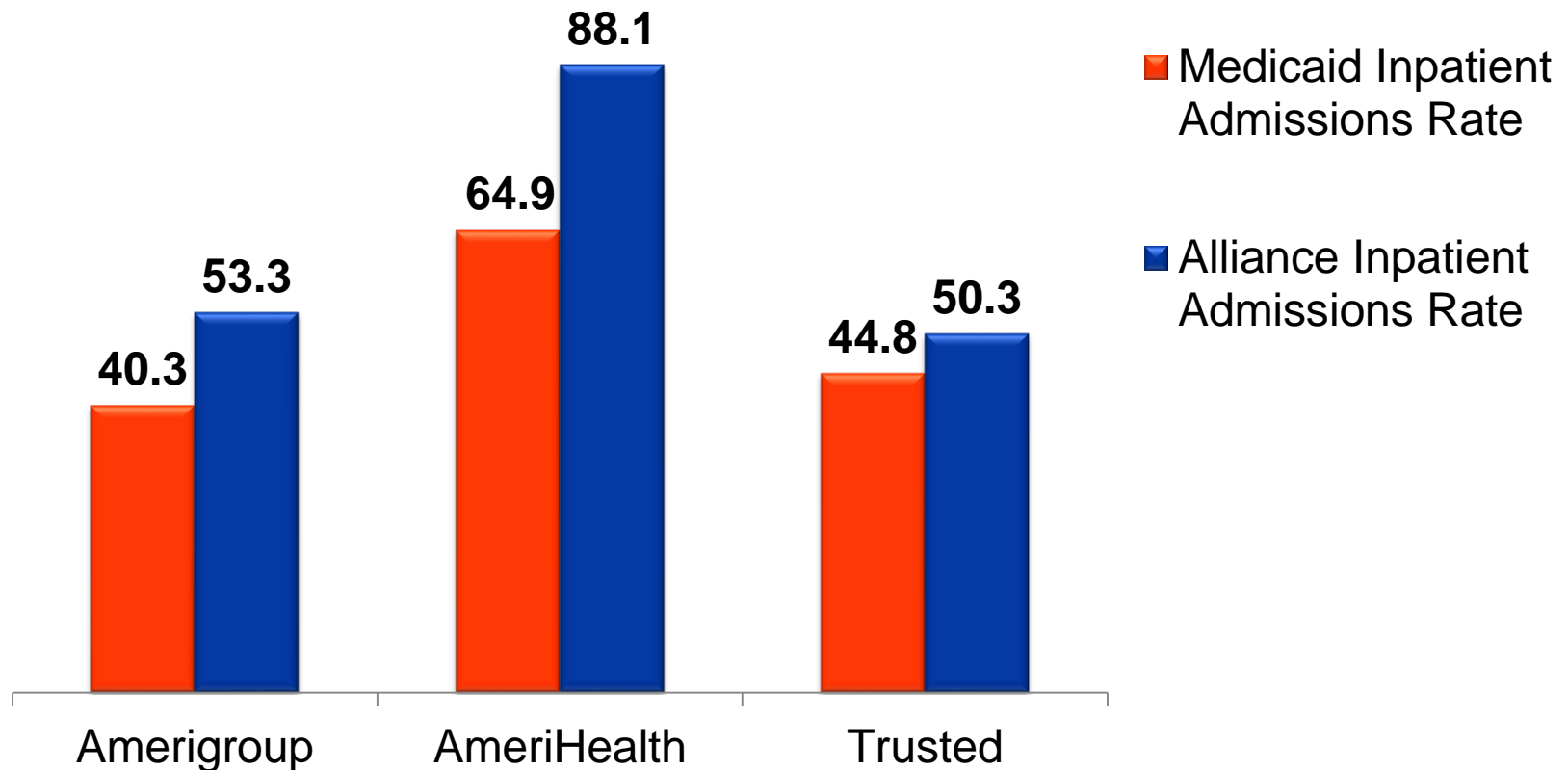
Percent Change in Expenses From YTD December 2017 to YTD December 2018



Notes: Change in average PMPM expense, January 1, 2018 through December 31, 2018 compared to January 1, 2017 through December 31, 2017 for AmeriHealth, Trusted and HSCSN. *For Amerigroup prior period is October 1, 2017 to December 31, 2017, as Amerigroup began operations in October 2017. Children defined as person up to age 21 in this analysis for the three full risk MCOs and age 26 for HSCSN. **HSCSN's financial results are reported in the aggregate. DHCF does not segregate HSCSN's financial results for the Special Needs and Well population. Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

AmeriHealth Inpatient Admissions Rates Are Significantly Higher Than The Other Two MCOs Undoubtedly Related To The Higher Risk Members That Have Transferred Into The Plan In 2018

Total Number Of Inpatient Admissions in CY2018 Per 1,000 Members

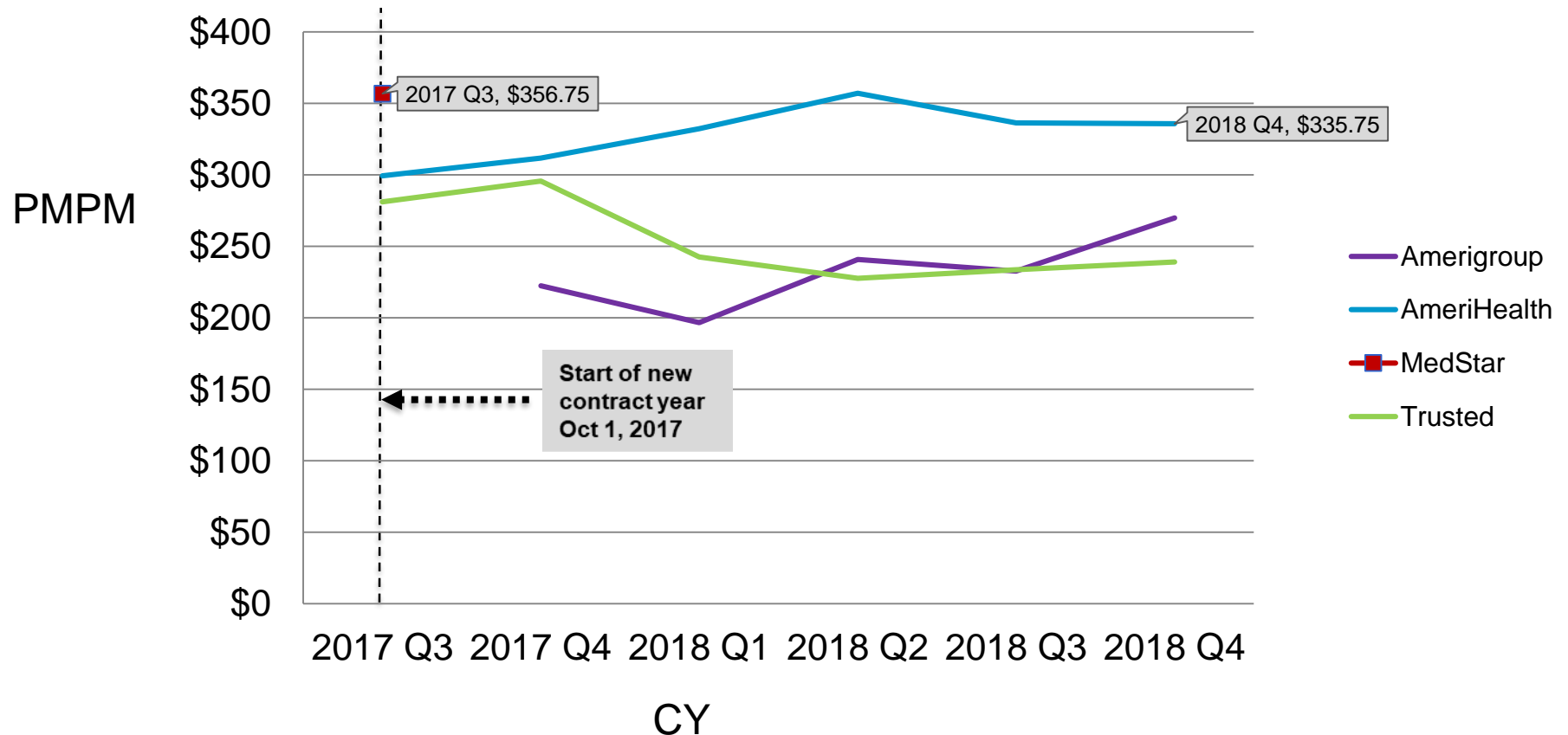


Notes: The current frequency of Index Admissions analysis for the period January 2018 to December 2018 includes encounters that are stamped by DHCF's MMIS both "Paid and Denied" encounters. These encounters include Medicare crossover claims.

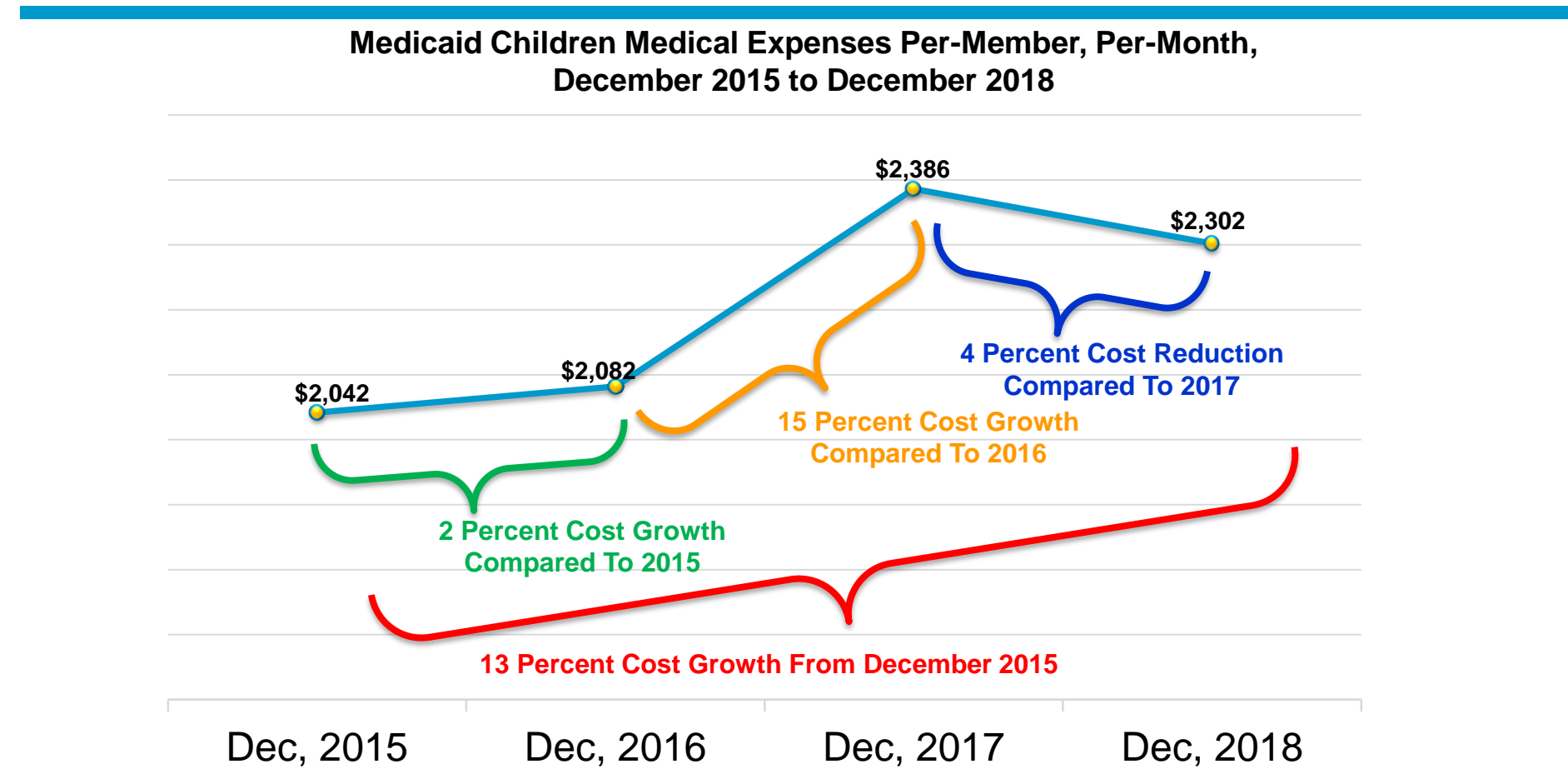
Source: Patient encounters with January 1-December 31, 2018 dates of service from DHCF MMIS system.

AmeriHealth's Cost Growth Aligns With The FY2018 MCO Contract Year And Transition Of The High-Cost Portion Of MedStar's Population To AmeriHealth

Total Medicaid Expenses Per-Member, Per-Month, for MCOs Contracted with the District from Q3 2017 to Q4 2018



HSCSN's Per-Member, Per-Month Medical Expenses For Children Declined In 2018 Due To Inpatient Trends, Compared To The Prior Year Spike In Costs Due To Specialty Drugs And Outpatient Claims From 2016 To 2017

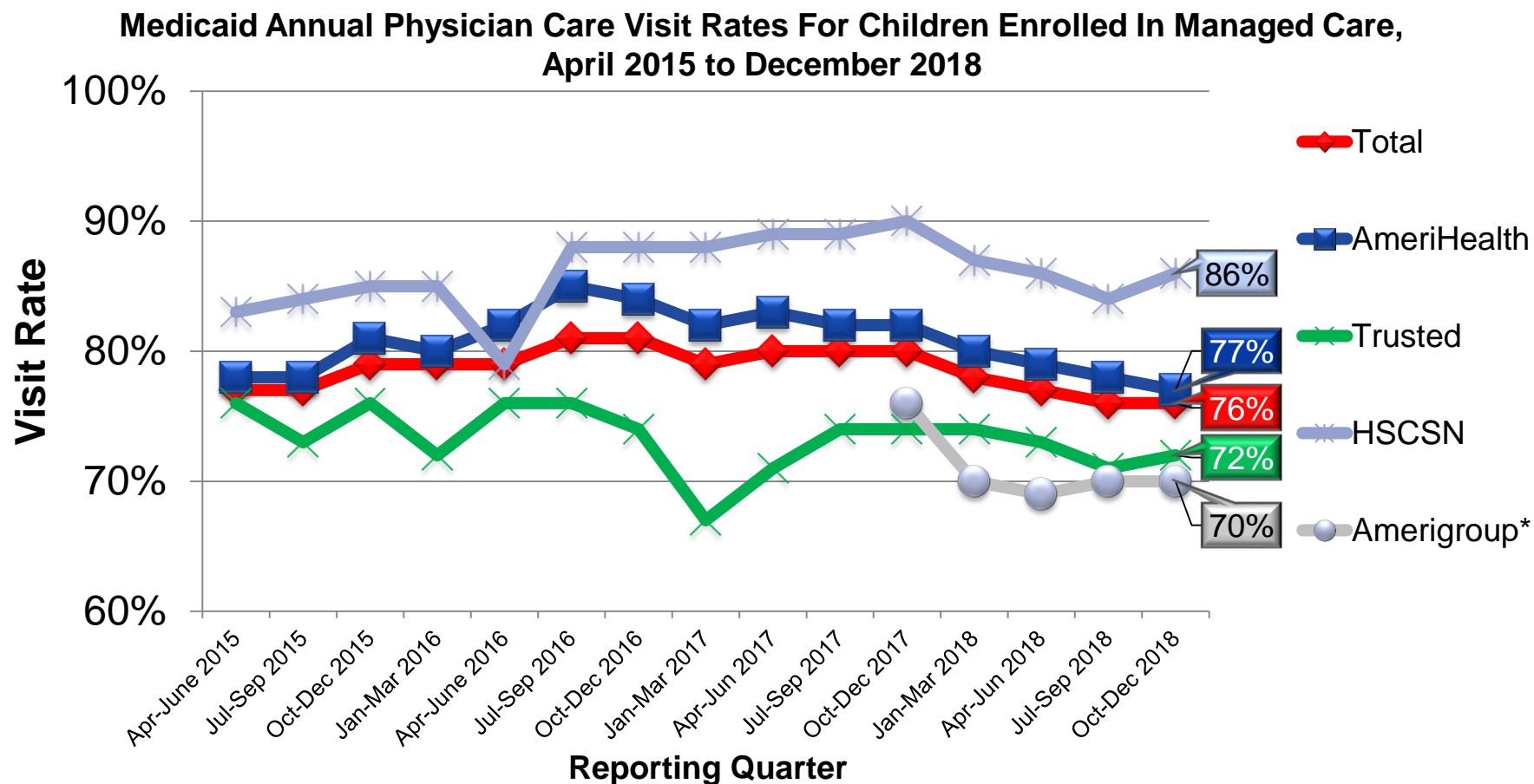


Notes: Expenses incurred from January 1, 2018 to December 31, 2018 and paid as of January 31, 2019. IBNR is estimated based on historical payment lags. This short runout period results in a high degree of uncertainty for IBNR estimates and final results will differ. Children defined as person up to age 26 for HSCSN. HSCSN's financial results are reported in the aggregate. DHCF does not currently segregate HSCSN's financial results for the Special Needs and Well population.

Source: Enrollment and expense data is based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

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Annual Children's Physician Visit Rates Decreased for Most Plans in CY2018

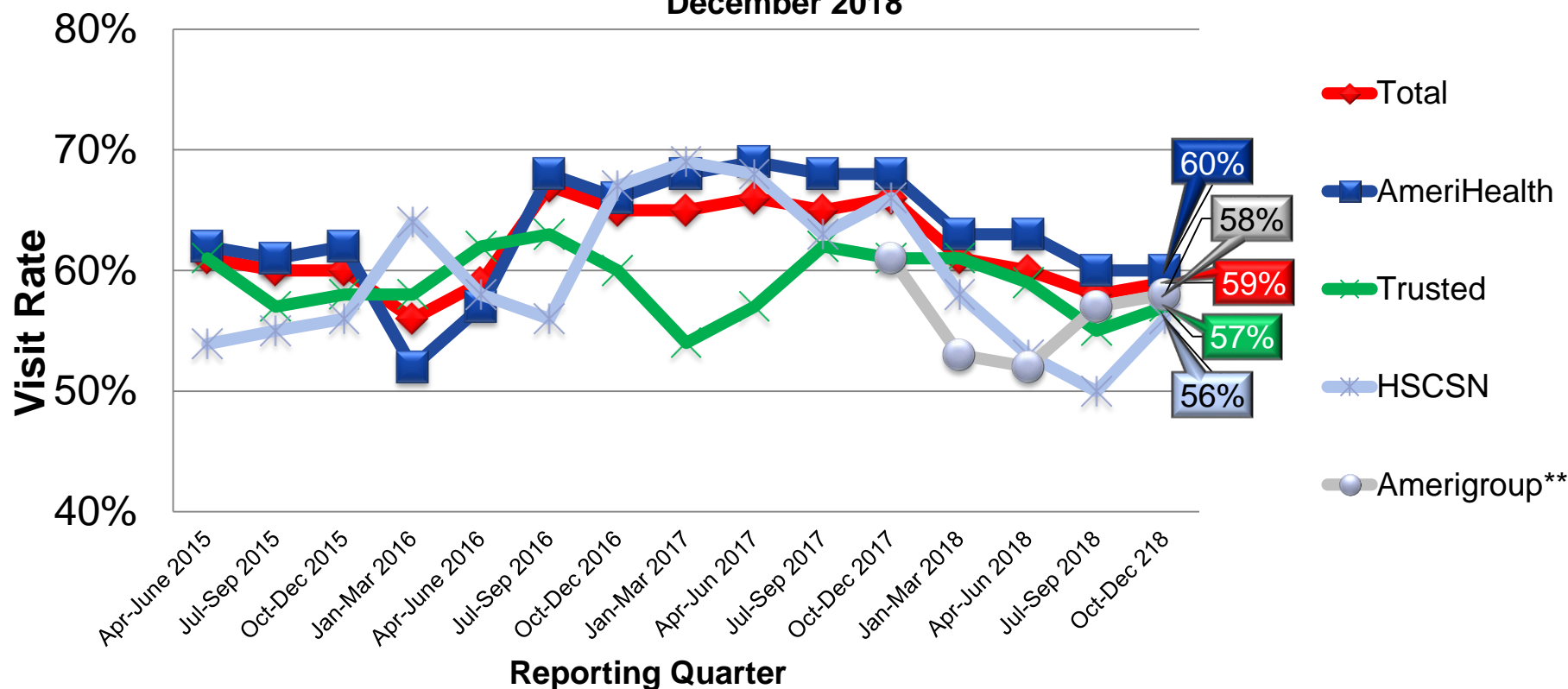


Note: In each quarter, only members who were enrolled with the MCO for three months continuously during the period and had 12 months of continuous Medicaid participation from that quarter are included in this analysis. This analysis is based on encounters from DHCF's MMIS system and does not include supplemental MCO data, which may cause results to differ from similar rates calculated in other reports. *In 2017 DHCF awarded new contracts for the District MCOs for FY18. Amerigroup's results represent data from October 2017 through December 2018.

Source Encounter data submitted by MCOs to DHCF.

Well-Child Children's Visit Rates Decreased for Most Plans in CY2018, Except Amerigroup*

Medicaid Annual Well-Child Visit Rates For Children Enrolled In Managed Care, April 2015 to December 2018

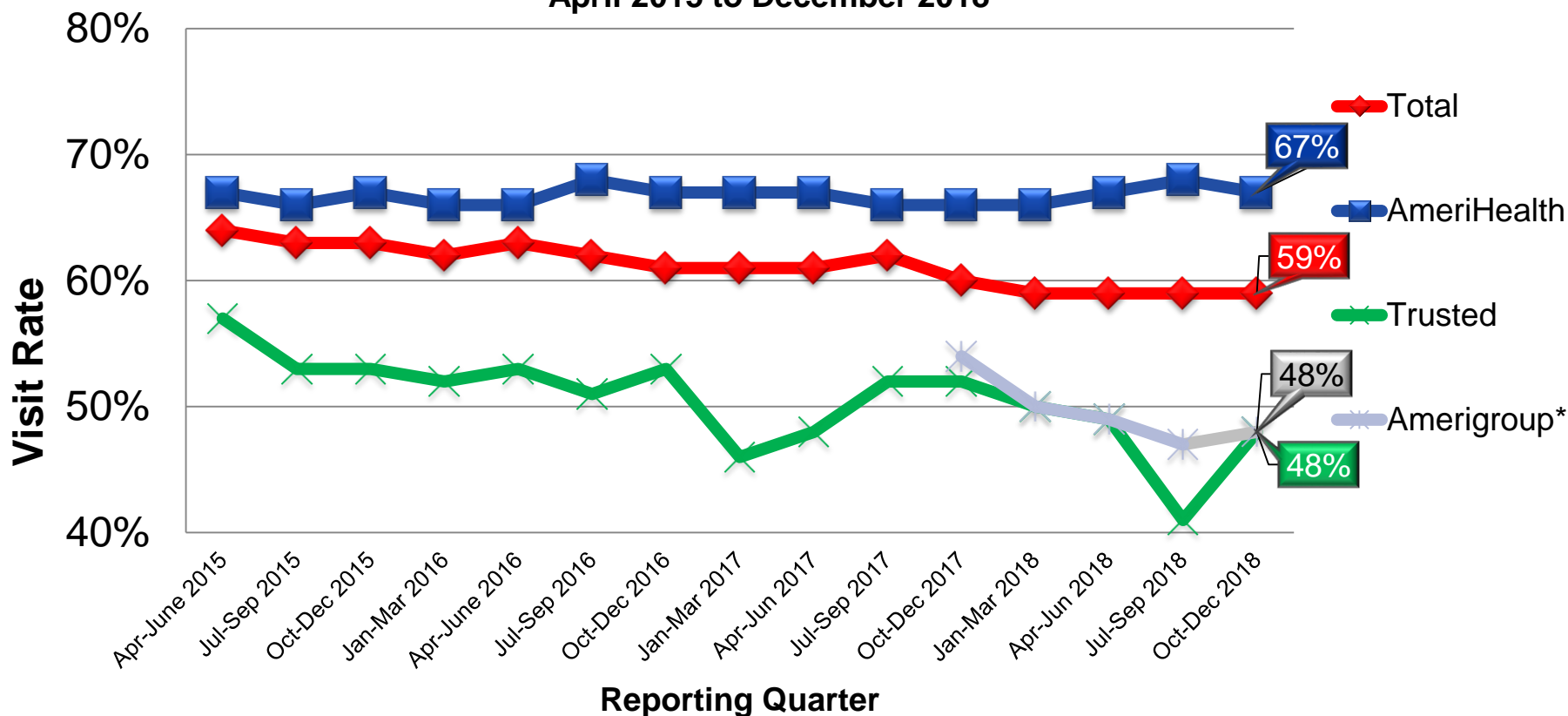


Note: In each quarter, only members who were enrolled with the MCO for three months continuously during the period and had 12 months of continuous Medicaid participation from that quarter are included in this analysis. This analysis is based on encounters from DHCF's MMIS system and does not include supplemental MCO data, which may cause results to differ from similar rates calculated in other reports. *Amerigroup anticipated that implemented medical record review processes would improve rates, and its well-child visit rates seemed to reflect that in 2018. AmeriHealth observed continuous influx of enrollment throughout 2018, which impacted the denominator and consequently reduced their overall visit rates. Trusted attributes the decline in well-child visits to a loss in eligible membership; while HSCSN's results increased in Q3 due to seasonality of services though ended up lower for the year compared to 2017 due to reduction in eligible members. **In 2017 DHCF awarded new contracts for the District MCOs for FY18. Amerigroup's results represent data from October 2017 through December 2018.

Source: Encounter data submitted by MCOs to DHCF.

Annual Adult Physician Visit Rates Are Mostly Unchanged, with Slight Increase for AmeriHealth and Decreases for Amerigroup and Trusted in CY2018

Medicaid Annual Physician Care Visit Rates For Adults Enrolled In Managed Care, April 2015 to December 2018

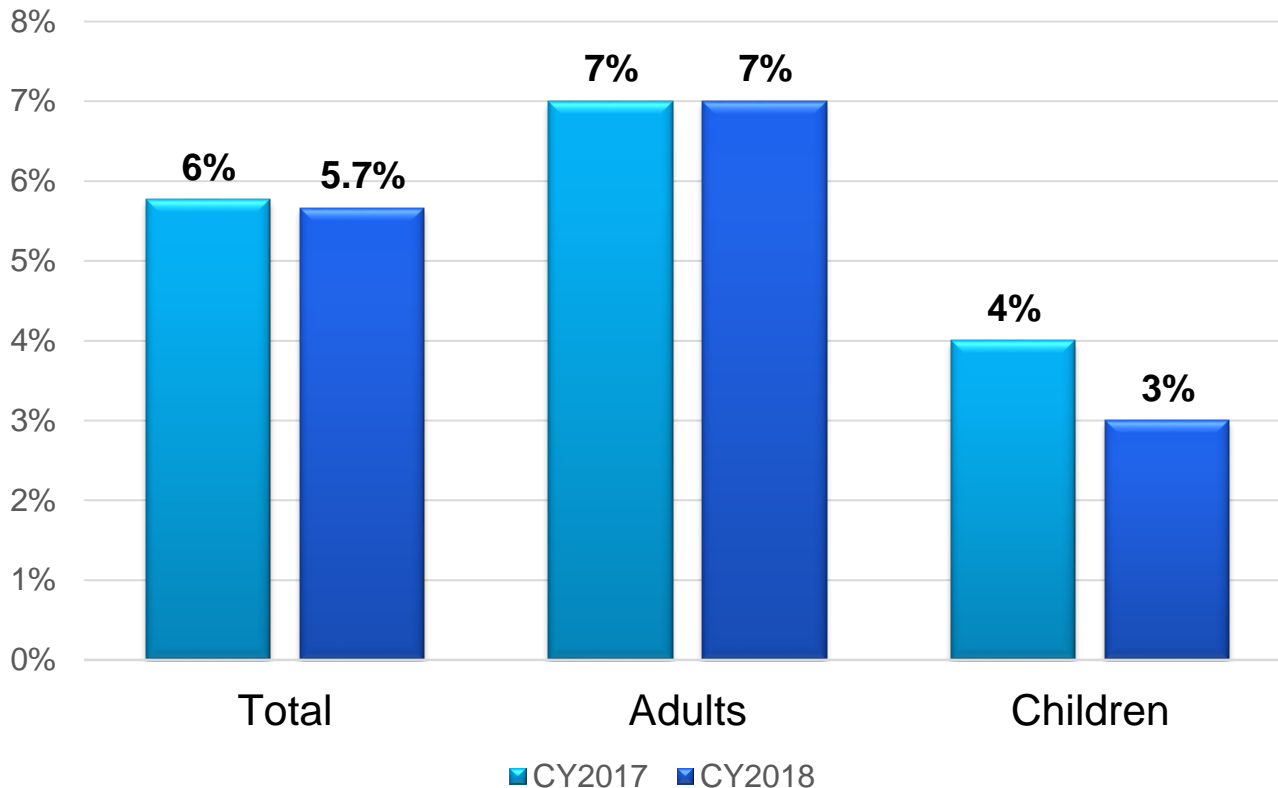


Note: In each quarter, only members who were enrolled with the MCO for three months continuously during the period and had 12 months of continuous Medicaid participation from that quarter are included in this analysis. This analysis is based on encounters from DHCF's MMIS system and does not include supplemental MCO data, which may cause results to differ from similar rates calculated in other reports. *In 2017 DHCF awarded new contracts for the District MCOs for FY18. Amerigroup's results for 2017 represent data from October 2017 through December 2018.

Source: Encounter data submitted by MCOs to DHCF.

Utilization Rate for Medicaid-Funded Mental Health Rehabilitation Services Decreased Slightly for Children from CY2017

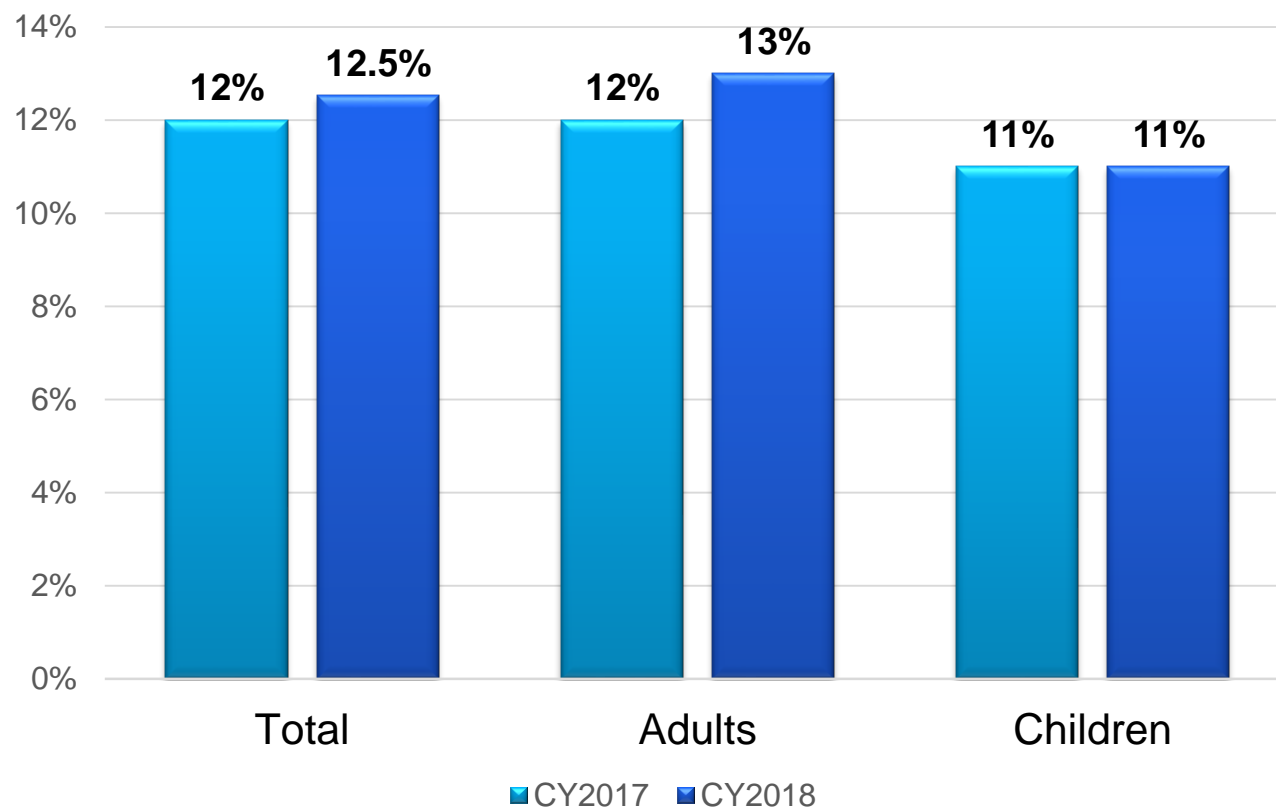
Percent of MCO Members Receiving Mental Health Rehabilitation Services Through MCOs, CY2017 and CY2018



Population Groups	CY2017	CY2018
Adults	136,721	139,681
Children	76,412	79,499
Total	213,133	219,180

However, MCO Penetration Rate for Beneficiaries Who Received Any Outpatient Mental Health Services in CY2018 Is Consistent with Rates from CY2017, and Slightly Higher for Adults

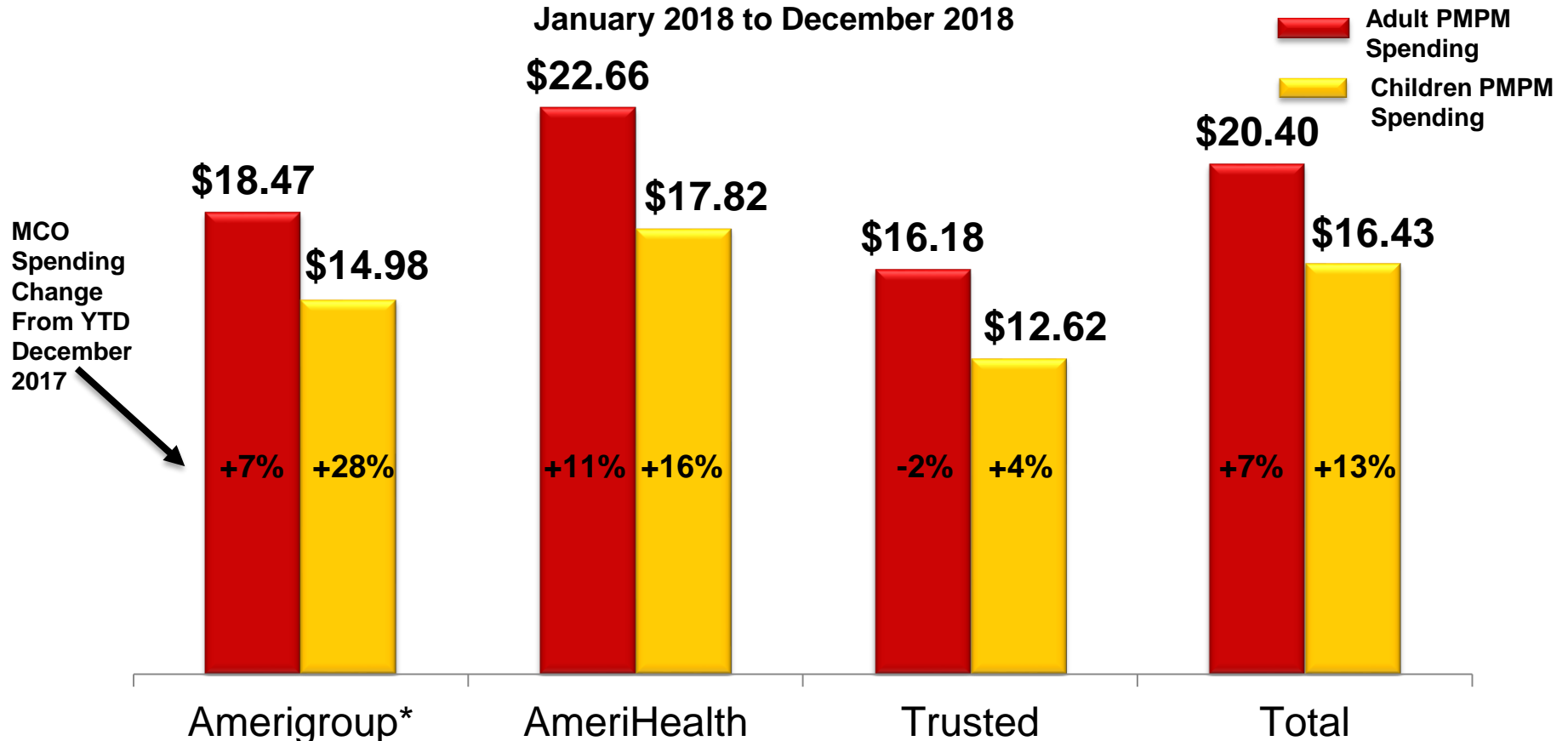
Percent of MCO Members Receiving Any Mental Health Services Through The MCOs, CY2017 and CY2018



Population Groups	CY2017	CY2018
Adults	136,721	139,681
Children	76,412	79,499
Total	213,133	219,180

Overall On A Per-Member Per-Month (PMPM) Basis MCOs Increased Spending On Medicaid-Funded Mental Health Services Year-Over-Year For The Past Five Years

The Per-Member, Per-Month MCO Expenses For Behavioral Health Services,
January 2018 to December 2018



Notes: Incurred from January 1, 2018 to December 31, 2018, paid as of January 31, 2019 for Amerigroup, AmeriHealth and Trusted. Change in average PMPM expense, January 1, 2018 to December 31, 2018 compared to January 1, 2017 to December 31, 2017. *For Amerigroup prior period is October 1, 2017 to December 31, 2017, as Amerigroup began operations in October 2017. IBNR is estimated based on historical payment lags. This short runout period results in a high degree of uncertainty for IBNR estimates and final results will differ. Children defined as person up to age 21 in this analysis for the three full risk MCOs.

Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

Presentation Outline

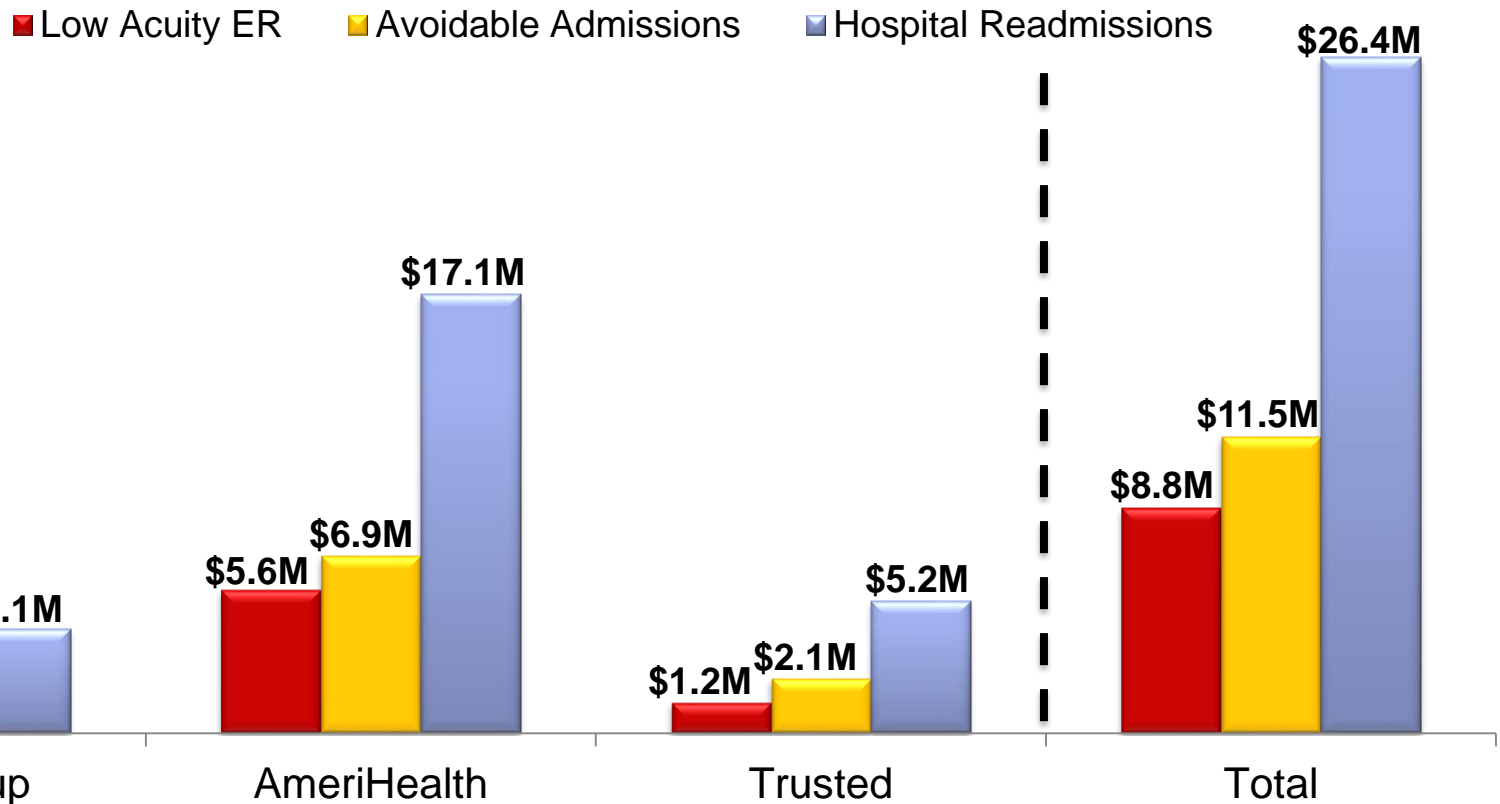
- ☐ Goals and Purpose of Managed Care Review
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- ☐ The Financial Performance of the District's Health Plans
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- ☐ Conclusions

DHCF Relies Upon Several Metrics To Quantitatively Assess The Efforts By The MCOs To Coordinate Enrollee Care

- ❑ Achieving high value in health care for Medicaid and Alliance beneficiaries is a preeminent goal of DHCF's managed care program.
- ❑ The District's three managed care plans are expected to increase their members' health care and improve outcomes per dollar spent through aggressive care coordination and health care management.
- ❑ After reviewing several years worth of data, DHCF can now more closely examine the following performance indicators for each of the District's three MCOs:
 - Emergency room utilization for non-emergency conditions.
 - Potentially preventable hospitalizations – admissions which could have been avoided with access to quality primary and preventative care.
 - Hospital readmissions for problems related to the diagnosis which prompted a previous and recent – within 30 days – hospitalization.

All Three Health Plans Can Save Millions By Reducing Their Medicaid Members' Use Of The ER For Non-Emergencies, Reducing Potentially Avoidable Hospital Admissions, And Slowing The Rate Of Hospital Readmissions

Managed Care Spending Attributed To Beneficiary Outcomes That Are Potentially Avoidable Through The Use Of Robust Care Coordination Programs



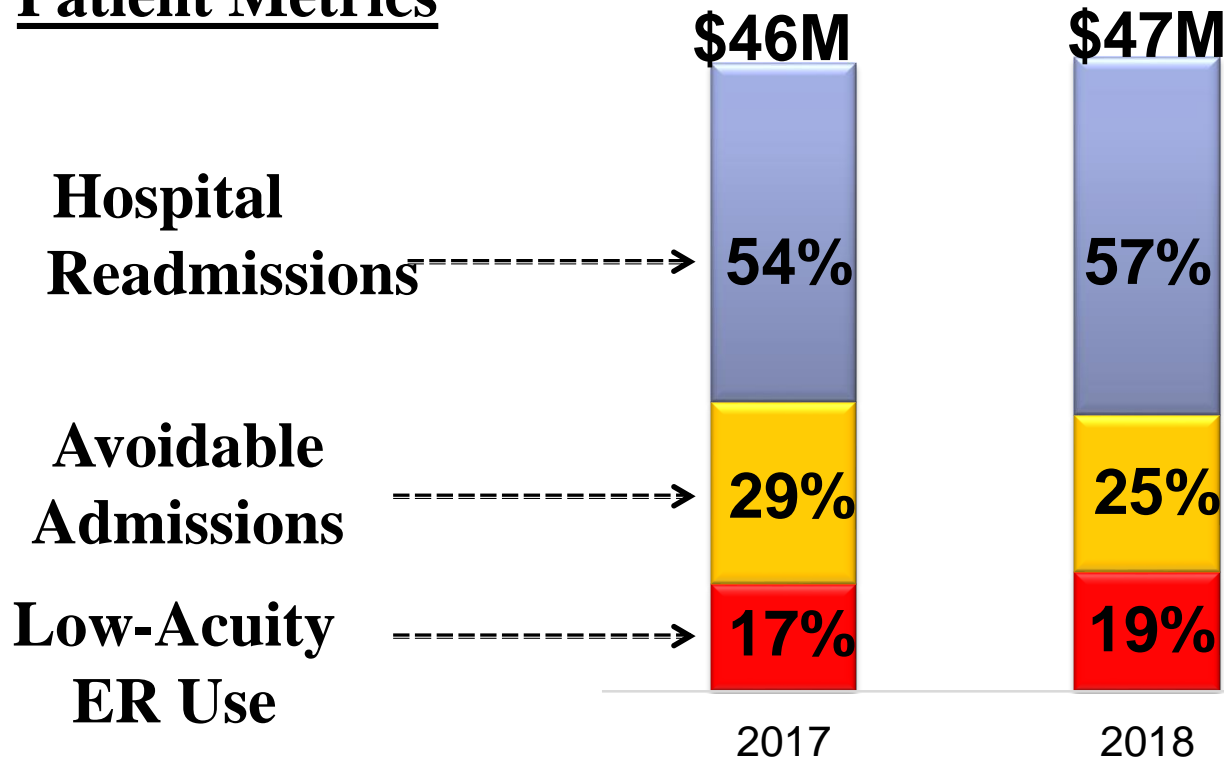
Notes: Current annual results reflect data incurred in October 2017 through September 2018 with payment runout through December 2018. Total avoidable costs include Health Home enrollees. The amounts listed as potentially avoidable would likely be offset by other costs if the MCOs improved their care management, such as increased outpatient costs due to increased use of outpatient facilities.

Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data for DCHFP submitted directly to DHCF.

In Total Approximately \$47 Million In Managed Care Expenses Were Potentially Avoidable*

Comparison Of MCO Potentially Avoidable Spending 2017 To 2018

Patient Metrics

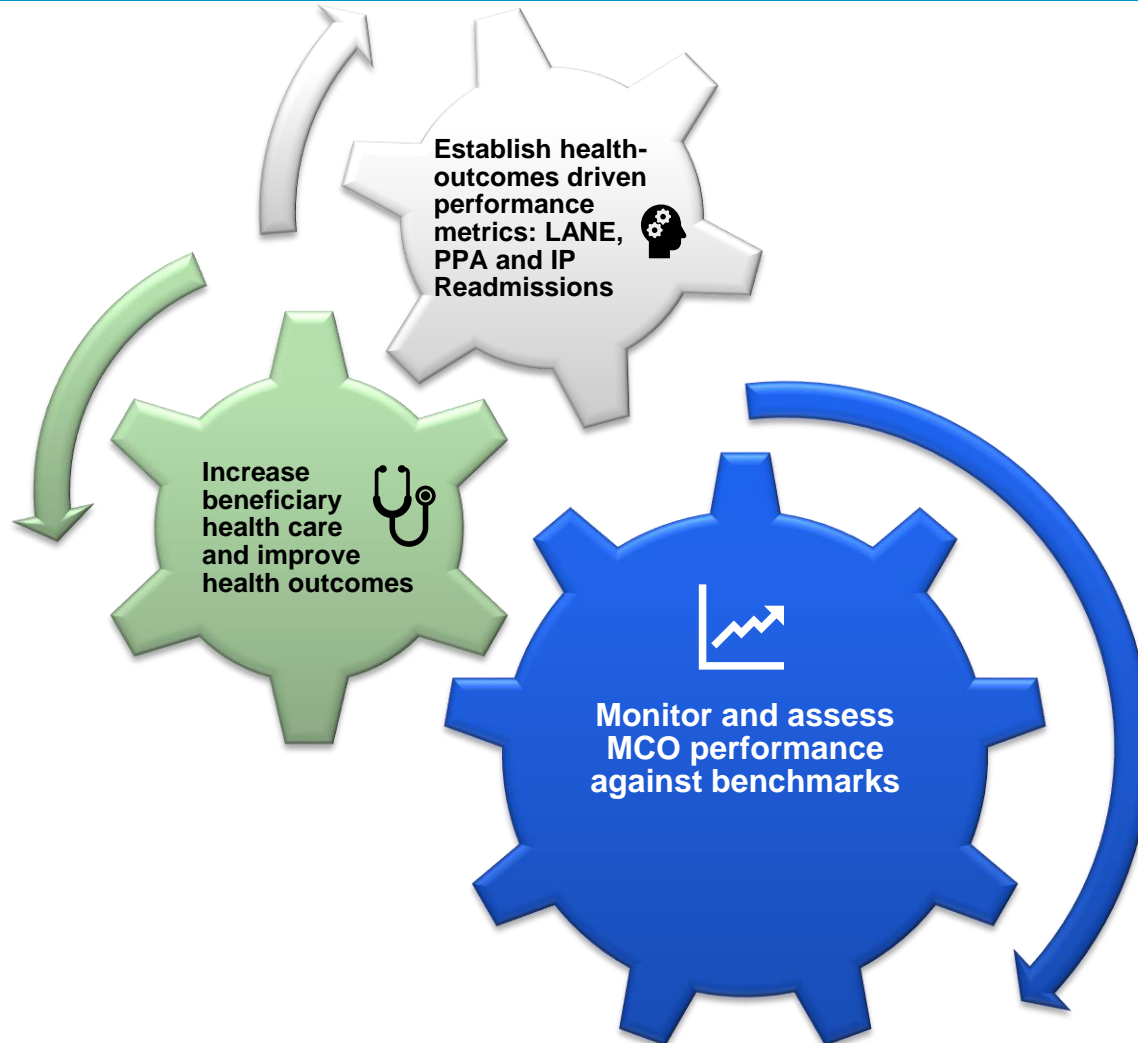


Notes: *Current annual results reflect data incurred in October 2017 through September 2018 with payment runout through December 2018. For 2017 data, the District previously contracted with MedStar during the period covered by this analysis. MedStar's results are included here for purposes of reporting impact of total avoidable costs on the Medicaid MCO program. The amounts listed as potentially avoidable would likely be offset by other costs if the MCOs improved their care management, such as increased outpatient costs due to increased use of outpatient facilities. Low acuity non-emergent visits are emergency room visits that could have been potentially avoided, identified using a list of diagnosis applied to outpatient data.

Avoidable admissions are identified using a set of prevention quality measures that are applied to discharge data. Readmissions represent inpatient visits that are within 30 days of a qualifying initial inpatient admission.

Source: Mercer analysis of MCO Encounter data for DCHFP reported by the MCOs to DHCF.

Pay-For-Performance (P4P) Process At A Glance



In FY2017, DHCF Launched Pay-For-Performance Program As An Incentive For MCOs To Address Care Coordination Problems

- ❑ Beginning in October 2016, DHCF's three full risk-based MCOs were required to meet performance goals in order to receive their full capitated payment rate.

- ❑ These performance goals require the MCOs to reduce the incidence of the following three patient outcomes for the DCHFP population:
 - 1) Potentially preventable admissions (PPA).
 - 2) Low acuity non-emergent (LANE) visits.
 - 3) 30-day hospital readmissions for all-causes.

Program Structure Is Based On Cash Withhold

- ❑ The program is funded through a two-percent (2%) withhold of each MCO's actuarially sound capitation payments for non-delivery DCHFP rate cells for the corresponding period.
- ❑ The 2% withhold is the profit margin for each MCO that is factored into the base per-member, per-month payment rate. Year 2 P4P actual results are based on FY18 (October 2017 – September 2018) experience compared to the Year 1 baseline.
- ❑ The baseline period used to set the target remains April 1, 2015 through March 31, 2016, with runout through September 2016. MCOs must meet the minimum threshold for improvement for all three performance measures in order to earn any portion of the withhold.

Weighting And Scoring System For Pay-For-Performance

- ❑ A scoring system was implemented to determine the distribution of payment incentives for the MCOs:

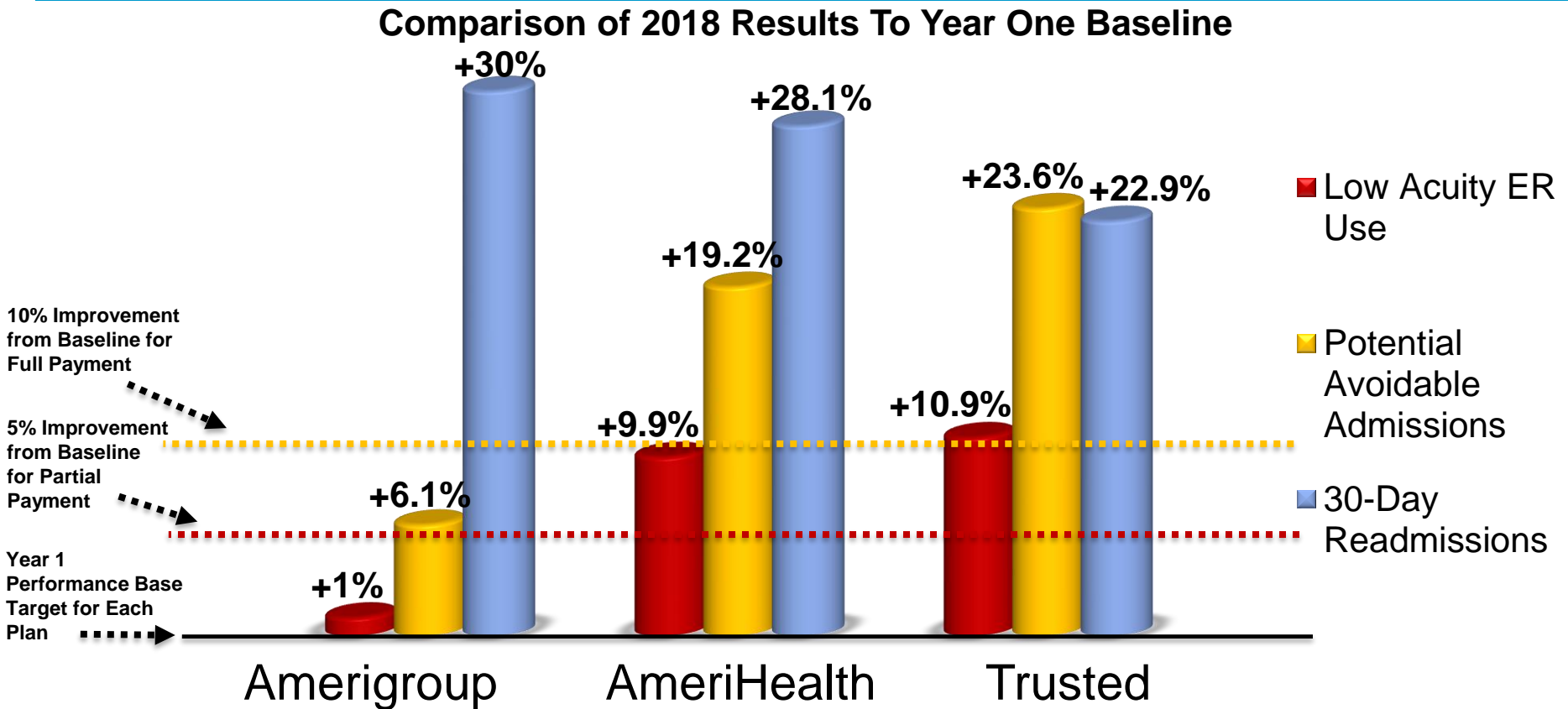
- ❑ LANE and PPAs will be weighted at 33% of the capitation withhold. The MCOs have an opportunity to earn back the full 33% based on performance as follows:
 - 10% reduction in LANE Emergency Department (ED) utilization and PPAs from the baseline will result in the MCO earning 100% of the 33% withhold attributed to each of these measures.
 - 7.5% reduction in LANE ED utilization and PPAs from the baseline will result in the MCO earning 50% of the of the 33% withhold attributed to these measures.
 - 5% reduction in LANE ED utilization and PPAs from the baseline will result in the MCO earning 25% of the 33% withhold attributed to these measures.
 - If reduction in LANE utilization and PPAs are less than the minimum 5% standard from the baseline, the MCOs do not earn any portion of the 33% withhold attributed to the relevant measure.

Weighting And Scoring System For Pay-For-Performance

(continued)

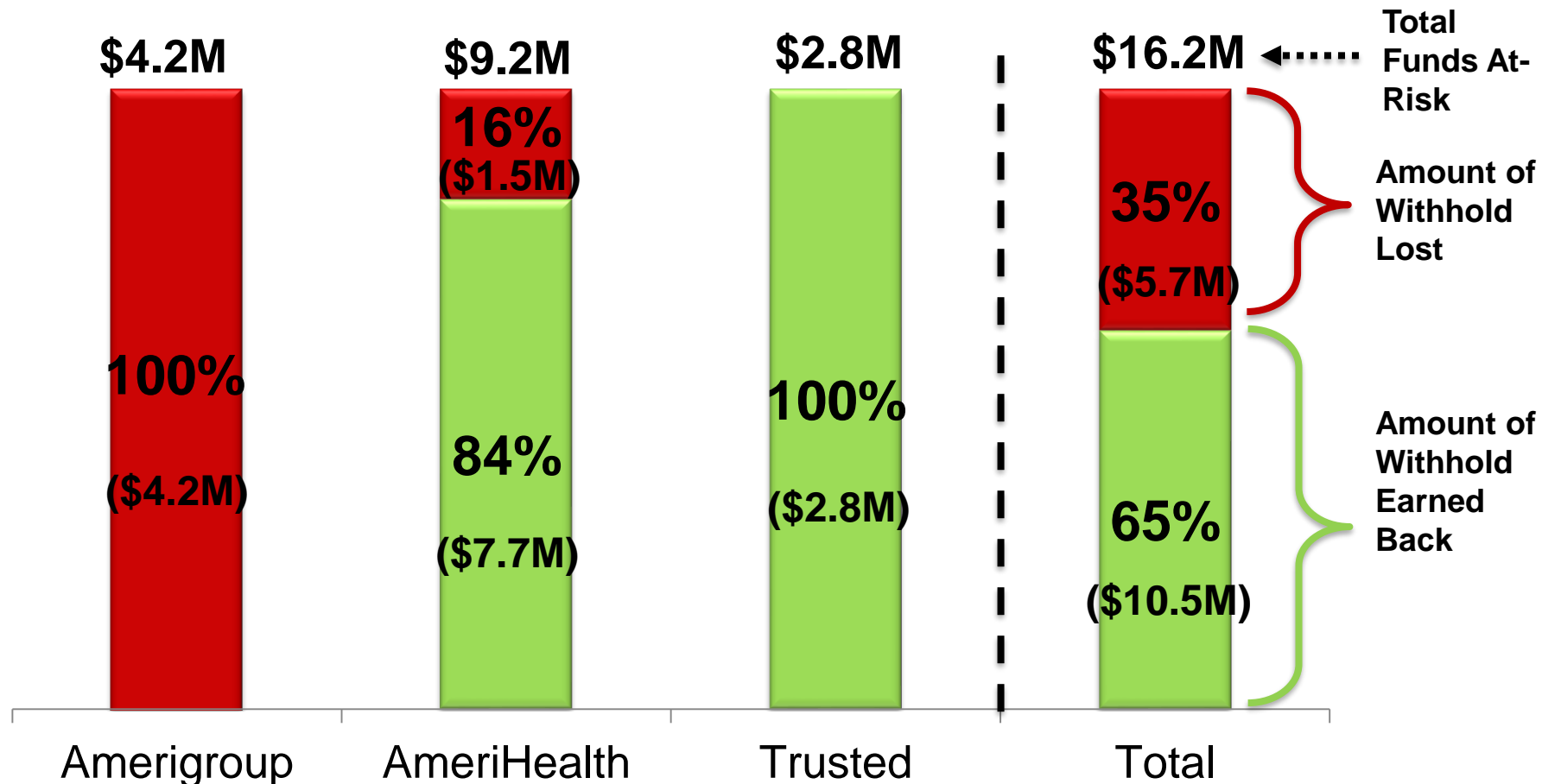
- ❑ The scoring system is the same for the third measure -- All-Cause Hospital Readmissions -- but this outcome is weighted at 34% of the capitation withhold.
- ❑ The MCOs can earn back 25%, 50% or 100% of the 34% withhold attributed to the measure by demonstrating reductions at 5%, 7.5% and 10% respectively.
- ❑ DHCF relies upon claims data to measure the MCOs' performance in this system. Since a run-out period must be allowed to ensure a more complete picture of claims activity, payments will likely occur 4 to 7 months after the measurement period closes.

When Comparing FY2018 Data To Baseline Results, AmeriHealth Met Minimum Standards And Trusted Met Full Standards On All P4P Measures, With AmeriHealth Receiving Partial Recoupment and Trusted Full Recoupment Of Capitation Withhold



Notes: Low acuity non-emergent visits are emergency room visits that could have been potentially avoided, identified using a list of diagnosis applied to outpatient data. Avoidable admissions are identified using a set of prevention quality measures that are applied to discharge data. Readmissions represent inpatient visits that are within 30 days of a qualifying initial inpatient admission. Year 1 Baseline reflects data incurred April 2015-March 2016. The Year 2 Pay-For-Performance target for each plan is set based on a 10% expected improvement to the baseline for each metric for full payment of withhold, and a 5% minimum improvement on each metric to receive any portion of withhold. Final metrics are net of Health Home enrollees. Current annual results reflect data incurred in October 2017 through September 2018 with payment runout through December 2018, compared to the Baseline. Source: Mercer analysis of MCO DCHFP Encounter data reported by the MCOs to DHCF.

The MCOs Earned Back 65 Percent Of The Performance Withhold Amounts



Presentation Outline

- ☐ Goals and Purpose of Managed Care Review
- ☐ Summary Of Key Findings
- ☐ The Financial Performance of the District's Health Plans
- ☐ The Administrative Performance of the District's Health Plans
- ☐ MCO Medical Spending and Beneficiary Utilization Patterns
- ☐ Care Coordination and Performance Against Program P4P Benchmarks
- ☒ **Conclusions**

Conclusions

- ❑ DHCF will closely monitor and focus oversight activities on the following areas in the coming year:
 - Continued erosion in MCO membership for Trusted and Amerigroup.
 - Disproportionate transition of high-cost beneficiaries from the other MCOs to AmeriHealth.
 - Failure of Amerigroup and Trusted to spend 85 percent of MCO revenue on beneficiary medical and quality improvement costs, potentially driven by high rate of claims denial particularly for Trusted.
 - Decline in annual physician and well-child visit rates observed for most MCOs.
 - Amerigroup's failure to meet minimum thresholds for improvement in P4P measures (LANE) to earn any withhold in 2018.

- ❑ DHCF will work closely with the MCOs to oversee the provision of managed care services to ensure access to comprehensive, quality and cost effective services for the District's beneficiaries.